MISUSED WORDS, MISLEADING THOUGHTS.

The Roles and Perceptions of Nurses, Doctors and Social Workers involved in the Discharge Planning Process and their affects on Communication.

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ABSTRACT.

Providing cost effective health care is a key objective of policy makers. This is predicated upon enhanced responsiveness through seamless working patterns and optimised communication practices. A model of discharge planning and practice is required which enables the appropriate transmission of information across boundaries, allowing more appropriate treatment following acute illness. This thesis examines impediments to the realisation of this vision. In particular:

- Are there differing perceptions amongst health care professionals regarding the role of other health care workers?
- If different perceptions do exist, how are they formed and how do they become current?
- Does this affect communication within the discharge planning process?
- How do such perceptions affect service provision to service users?

Study design.

A three-phase ethnomethodological study was conducted. A Likert Scale was used to identify common factors influencing the discharge planning process. Interviews were carried out with personnel involved in discharge planning at two acute care facilities and GP practices. Interviews were also conducted with service users before and after their discharge from hospital.

Findings.

Language use among staff served to achieve consensus and mediate conflict, producing a shared vision of a social reality that was favourable to occupational groups. Poor information sharing and poor communication allowed sectional interests to dominate as occupational groups attempted to ensure equitable division of labour and use of resources. Time, staffing levels and negative perceptions exacerbate poor communication and are reinforced by it. Strategies are outlined and discussed.

"How often misused words generate misleading thoughts".

Herbert Spencer, Principles of Ethics; 1879 (in Partington 1996).

1.1: Chapter One. The research aims introduced.

The aim of this study is to examine communication practices among doctors, social workers, nurses, district nurses and discharge planners involved in the transfer of vulnerable adults across the primary-secondary health care interface. Poor discharge outcomes may be classed as early readmission, inappropriate resource use and adverse therapeutic events and such outcomes are the result of the influence of a number of factors which this study seeks to explore. These factors are role perception, organisational arrangements, conflict and communication. The study also highlights areas of good, as well as poor, practice within the sphere of discharge planning and suggests improvements. The research questions, therefore, are:

- Are there differing perceptions amongst health care professionals regarding the role of other health care workers?
- If different perceptions exist, how are they formed and how do they become current?
- Does this affect communication within the discharge planning process?
- Finally, how do perceptions held by professionals affect service provision to clients?

1.2: The methodology introduced.

To examine the above, this study used ethnomethodology. This methodology allows exploration of the different realities and perceptions under which occupational groups operate, as well as the communication practices, and practical responses. The nature of ethnomethodology, the structure of the study, and the justification and implications of the methods and instrumentation used are discussed in chapter two.

1.3: The Order of the Chapters.

This chapter provides the context and background to the study, as well as an initial review of the literature. Chapter two forms a discussion of the methodology used in the study and states the research questions. Chapters three and four describe the findings of the two phases of the study. Chapter five contains a discussion of the findings with reference to current literature whilst chapter six contains the concluding remarks and recommendations for practice

1.4: The literature review: rationale and search methods.

The literature review comprises two sections. The first section (chapter one) represents an appraisal of the literature at the time the thesis was commenced. It is an exploratory review undertaken at a time when literature search and review methods were less exact than at present. The second part of the literature review (which forms chapter five) is a summative review in which the most current literature findings are used to discuss findings from the two phases of data analysis. The division of the literature review in this manner serves to provide a longitudinal dimension to the literature, the monitoring of important issues within the discharge planning process over time and in relation to the qualitative data. The RCN Institute (1997) argues positively in this vein, asserting that:

> *"Those who work from other perspectives [non-positivist] would put forward different arguments...Most would suggest that, in order to be able to justify one's own study and, in particular, in order not to reinvent the wheel, a literature search in the early stages of the study is important to establish the nature of the conversation and the arguments which are being aired rather than identify exhaustively what has been, or is being said. As with positivist research, the search should be ongoing to identify fresh dialogue. However, since the nature of the findings is invariably unexpected, or, at least, uncertain, a further literature search is likely to be needed once the data have been analysed and interpreted to identify other voices debating the same issues or the lack of such voices".*

The search frame was compiled using an encyclopaedia (Hutchinson 1999) and a specialist subject dictionary (as recommended by Hart 2001; see also Lloyd, 2004)

in this case a nursing dictionary. Synonyms and antonyms were also included and this gave an initial search frame of 160 keywords (of which 32 were health related organisations on the internet). This gave the following keywords (given in table 1.1 below). Because of the large number of articles, it was necessary to refine the list of keywords as the amount of duplication and irrelevant material would have meant an unreasonably lengthy period of literature searching. The limits set were articles in English between the dates 1998-2004. Databases were searched at Birmingham (UCE and University of Birmingham), Manchester University and the University of Wolverhampton.

Table: 1.1 Databases,. keywords, number of hits and number of hits used during literature search.

Database.	**Keyword(s).**	**Hits (used).**
Oxford University Press	Discharge	203 (44)
Cambridge University Press	Nursing process	215 (11)
	Audit	7 (0)
	Audit Commission	49 (2)
	Barrier nursing	19 (1)
	Care	402 (45)
	Care pathways	1 (1)
	Carer	4 (1)
	Communication	111 (1)
	Community medicine	188 (15)
	Competence	35 (1)
	Continuing care	258 (19)
	Palliative	8 (3)
	Nursing	16 (7)
ASSIA indices	Discharge planning	630 (129)
	Ethnomethodology	2 (2)
	Discharge liaison	1 (1)
	District nurses	24 (7)
	Macmillan nurses	3 (0)
	Medical social worker	0 (0)
	Nursing	2463 (27)
	Nursing AND hospital	720 (42)
Medline	Discharge planning	200 (39)
	Discharge liaison sisters	0
	Discharge liaison nurses	0
	Discharge liaison	89 (13)
	District nurses	200 (32)
	Voluntary services	200 (19)
Lancet Elsevier Scientific	Discharge planning	289 (30)
British Library.	Discharge liaison	2 (2)
Blackwell Synergy	Ethnomethodology	55(
	Triangulation	604(
	Qualitative Research	
Cochrane Library	Discharge Planning	89(9)

1.5: Key terms defined.

a) The primary/secondary health care interface.

The primary secondary health care interface is defined as the point where community agencies (primary) meet inpatient/hospital facilities (secondary). The boundary is not static but changes in response to external events. This, in turn, produces conflict that affects continuity of care within the discharge planning process. The boundary also serves to colour the views of people concerning the distribution of resources and the nature of other disciplines.

b) Continuity of care.

Synonyms for continuity of care include seamless care, integrated care and multidisciplinary care, as well as boundary-less organisations. Anderson and Helms (1993, p.41) define continuity of care as "a series of linkages across time, settings, providers and consumers of health care". The proper implementation of this concept will ensure that a person's progression through the stages of illness will be psychologically, socially and therapeutically atraumatic.

c) Discharge and discharge planning.

Anderson and Helms (1993) note that discharge planning is a "process of identifying continuing needs and co-ordinating care with appropriate service providers at the next level of the health care delivery system". Gregory (1992) claims that safe discharge occurs when a patient's treatment is completed and the community support systems are in place, their rigour and appropriateness having been assured.

1.6: Initial review of the literature.

Initial examination of literature revealed themes of appropriate bed use versus demand, the importance of throughput and communication (especially written). Quality of communication as an influence on role perception and responsibility also emerged as a theme. Communication was influenced by socialisation and organisational demands

(causing a reduction in patient contact through sublimation of the caring discourse). Lack of time served to heighten nurses` feelings of stress, as did excessive or conflicting organisational demands. At this early stage it appears that the reasons for poor discharge outcomes are multifactorial but that all such factors impact negatively upon vulnerable individuals and their carers (reduced mortality and reduced functional ability). All of the above factors will be discussed in the following sections.

A National Audit Office (NAO) (2003) report claims that in September 2002, 8.9% of persons aged 75 and over had been declared medically fit for discharge and yet remained in acute NHS beds (p.1). This totals 4,100 patients per day. The commission for Social Care Inspection noted that in 2003 up to 3000 people per day were unable to be discharged from hospital though fit enough. The reasons for delays are given in figure 1.1 (below).

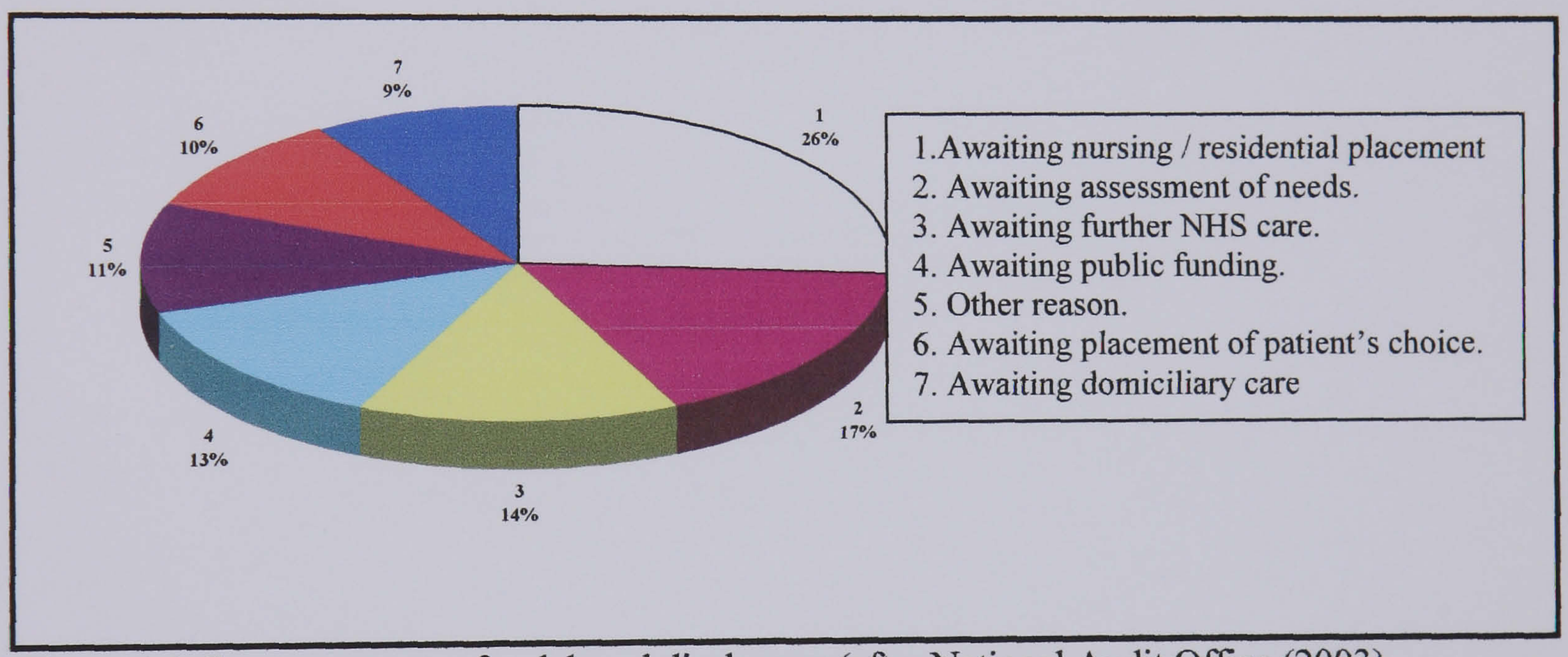


Figure 1.1 Common causes for delayed discharges (after National Audit Office (2003).

Given the above statistics, timely and appropriate discharge planning has not diminished in importance. Feather (1993) asserts that discharge planning has been part of hospital and social work practice for at least fifty years but the need to curb healthcare spending, reductions in the length of hospital stays, and the consequent increase in the number of vulnerable hospitalised individuals, have all served to massively increase the need for an effective discharge planning process.

Bagust, Place and Posnett (1999) note that the balance between emergency and elective patients is shifting such that emergency admissions currently occupy approximately 65% of all staffed beds. They note that risks are minimal as long as

the mean bed occupancy remains at 85% or less. Above this level, however, the risk of not being able to accommodate emergency patients rises substantially such that at levels of bed occupancy "above a mean level of 90% a hospital will be subject to regular bed crises". They note too that the effects of the cancellation of emergency patients are long lasting. Based on an average length of stay of two weeks for the emergency patient "a hospital that runs out of beds for four days in the year may be disrupted for eight weeks in total". Figure 1.2 (below) gives the relation of performance risks to average bed occupancy as simulated by the model.

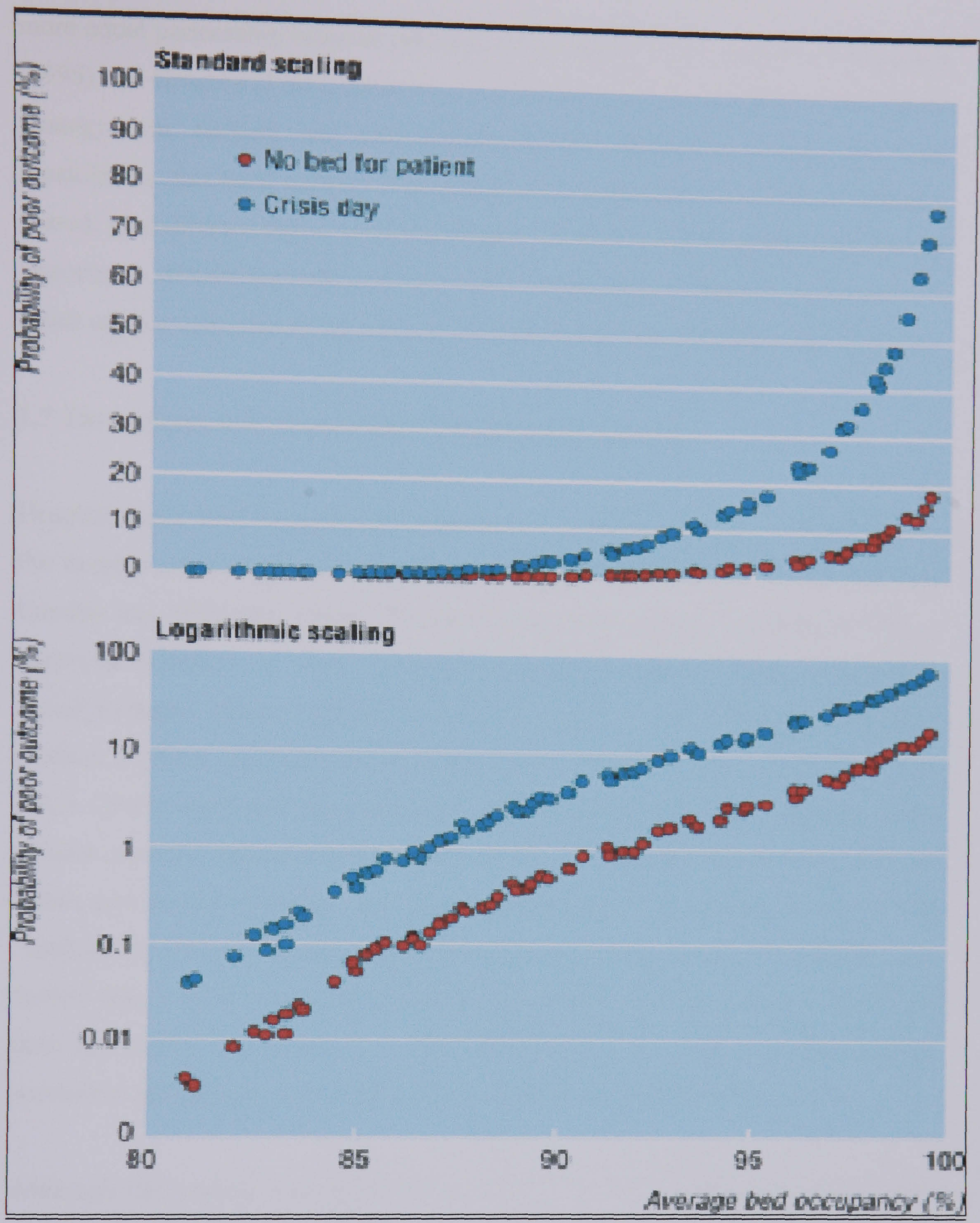


Figure: 1.2 The Relation of Performance Risks to Average Bed Occupancy. (After Bagust, Place and Posnett 1999).

In "Our Healthier Nation" (DOH 1999) the government recognises that health inequalities may be exacerbated by the way in which healthcare provision is organised. Moreover, the NHS Plan (2000) outlines a vision of a responsive health service in which local health issues will be managed by local people, facilitating flexibility and responsiveness to healthcare needs. Importance is also placed upon the shift from patterns of healthcare dominated by the secondary sector to those of a

more equal partnership between primary and secondary care. Allsop (1995), Klein (1995) and Gregory (1992), however, contend that in previous initiatives an overall strategy was lacking and that communication difficulties caused the very breakdowns that such policies were designed to overcome. In order to impart a shared, goal-directed vision of future health policy, the Government recognises the importance of communication (DOH 1997). Uncertainty remains, however, as a result of poor communication, sectional interests and fear, which provoke conflict.

1.7 Throughput and current discharge planning practice.

Hospital-based staff measure performance of a department in terms of throughput, the number of elective and emergency admissions successfully treated (see also Lundhu and Williams, 1997). Hospital based staff appear, however, to have a narrower definition of what constitutes successful treatment when compared to social workers. Nurses' definitions may be limited to the presenting surgical or medical problem and none of the wider issues that centre upon discharge. The NAO (2003) notes that the number of Trusts starting discharge planning at the earliest possible opportunity has fallen since 1999 despite the fact that 82% of Trusts now have a discharge co-ordinator and 66% have a discharge team. By the "earliest opportunity" is meant prior to patient admission. The NAO (2003) notes further that 30% of Trusts did not begin assessment even for planned admissions until the patient was admitted. This has an effect on communication between secondary and primary care which, in turn, affects the ability to plan care.

Although GPs would have preferred to receive the letter in the twenty-four hour period immediately following discharge (Gooder and Charney 1992), the time it took GPs to receive discharge summaries varied from 4.3 days (Penney 1998) to eight days (Mageean 1986). Closs (1997) found that almost one third of district nurses and health visitors surveyed found information contained within discharge summaries to be of an unacceptably low standard. Sixty-three percent of these staff had uncovered important information by other means, findings echoed by Cortis and Lacey (1995) and Hampson (1996). Other members of the community care team wished to receive information concerning the patient before discharge. Hampson estimated that the number of discharge summaries which never arrive is

between four and twenty-five percent.

Multidisciplinary or joint documentation is often seen as a method by means of which poor quality of information of the sort highlighted above can be addressed, but this has shortcomings. Barrett (1994) introduced multidisciplinary patient records, which improved communication and discharge planning but some duplication of paperwork was noted. The fact that single documentation exists is no guarantee of its effectiveness, language use is crucial in this regard. Brocklehurst and Butterworth (1986) examined 58 sets of notes for comments on discharge arrangements. They found that the majority of notes contained only the briefest of comments and further:

> *"There was a male patient, admitted to hospital with shortness of breath, lower chest pain, fever and cough. He was in hospital for thirty-two days. There was only one entry in his nursing notes regarding discharge, entered on day twenty: `expresses a wish to go home, awaiting to be seen by medical staff`. During his stay he had been seen by the occupational therapist, physiotherapist, community liaison team and social worker. On discharge, arrangements were made for him to see a district nurse, GP and counsellor. None of these details were mentioned in his notes".*

This fall in forward planning has occurred despite the fact that discharge policies are "almost universal". This suggests that the addition of other staff serves to fragment service delivery and that discharge policies are not fulfilling the role for which they were designed. The authors of the Climbie Enquiry report (2003) note that:

> *"The problem is less about staff being able to read and understand guidelines and more about the huge and dense nature of the material provided for them. The challenge is to provide busy staff in each of the agencies with something of real practical help and manageable length".*

Inability to comprehend proper discharge procedures and the rushed nature of discharge arrangements means that mistakes are more likely to be made and that discharge planning arrangements can be circumvented to minimise workload by using varying interpretations of eligibility to deflect responsibility for service provision. In the case of

those elderly persons with multiple medical problems this may mean an overly long stay in an acute bed. The Climbie Enquiry (2003) asserted that:

> *"...many of those from social services... spend a lot of time and energy devising ways of limiting access to services and adopting mechanisms to reduce service demand".*

1.8 Role Perception and responsibility among nurses and social workers.

The above statement would seem not to apply solely to social workers. Given that, as the preceding sections have demonstrated, discharge planning remains hurried despite the introduction of discharge planners and discharge policies and that information provided to other agencies is of a standard which is sufficiently low to jeopardise the ability to provide required care, it is perhaps more accurate to state that problems exist both within and between agencies. Relationships are problematic because of confusion over roles and responsibilities and this leads to inhibited communication patterns. As two of the most prominent occupational groups within the NHS, an examination of the relationships that pertain between these two occupations may serve to illuminate problems that exist within and between occupational groups as a whole.

Connolly (1995a) found that senior nurses wanted social workers to act as a bridge between health and social care through the provision of practical services. This leads to a distorted opinion of social work within the hospital setting, stemming from lack of clarity regarding the role and responsibility of the social worker (see Davies and Connolly, 1995a and b). Adjaye (2003) noted that many social workers felt "deskilled and devalued, that their professional expertise was not appreciated" and "their opinions were not always heard". Adjaye (2003) also noted problems in referring to social services and that "this caused negative feelings about social workers in general which can be unjustified". Key social workers felt that "both groups misunderstood each others` role which hindered communication".

> *"...Nurses are more likely than social workers to view most of the investigated chores as belonging predominantly to the domain of their profession, whereas social workers tend to*

pull toward their involvement in rendering each specific psycho-social assistance" (Ben-Sira and Szyf 1992).

Davies and Connolly (1995a) suggest that a number of hospital-based social workers felt themselves to be outside the boundaries of the traditional hospital partnerships. Adjaye (2003) also found that social workers stopped attending multidisciplinary team meetings despite the admission that attendance forms a key part of their role, allowing exchange of information between staff and giving social workers a more complete insight in to particular cases. The National Audit Office (2003) also identifies poor communication as one of the principal barriers to effective management of delayed discharges.

Nurses also appear to actively perpetuate the belief in professional demarcation, which has the effect of preventing social workers from providing sustained input in some cases. Ben-Sira and Szyf (1992) found that nurses viewed anything concerned with medicine such as the discussion of medical treatment, diagnosis and fears relating to disease (affective components) as almost exclusively their domain. They viewed possible disruption of patients' finances and lifestyle (instrumental components) as the domain of the social worker. There is, therefore, confusion concerning the role and expectations of groups within the health care setting. This is especially true when roles are seen to overlap. This is not a situation that can be remedied by the groups themselves for, as Cortis and Lacey (1996) point out, organisational problems demand organisational answers.

Tensions between the different disciplines are also reflected in Rothermich et al (1996) assert that the majority of complaints concern colleagues who are perceived to be abrasive, self-centred, uncooperative and unappreciative. Rothermich (1996) further asserts that the individual who feels wronged becomes withdrawn and defensive, his or her capacity to influence the working environment for the better becomes severely limited. Rumour may also supplant normal communication processes, causing a lowering of morale and increasing the likelihood of the defensive posture. This "defensive posture" then becomes the individual's habitual way of dealing with colleagues. This defence of territory is attempted by stereotyping the roles of others in order to belittle the contribution they make, a phenomenon also noted by Iles and Auluck (1990).

This posture becomes possible because the NHS contains a number of professional bodies whose members are identifiable as members of the group to which they belong rather than as members of the NHS as a whole. Wilkins and Ouchi (1983) assert that these subgroups of the organisation are likely to form when there is a long history, a stable membership and an absence of institutional alternatives. If these clans have rigid boundaries, this leads to antipathy and mistrust towards other groups whilst resultant poor communication results in further negative perceptions of out-groups. These negative traits may be further fostered by socialisation and training. Bourne and Ezzamel (1986), in reference to the British National Health Service, assert that where there is a high degree of goal incongruence and a low degree of ambiguity in performance measurement, the market system is the most suitable method of control. The NHS they assert, however, has a high degree of ambiguity in performance measurement and a low degree of goal incongruence. They concur with Wilkins and Ouchi (1983) that clans would come to dominate.

Although groups may be maladaptive, creating uncertainty regarding professional identity (see Williams and Sibbald 1999), leading to low morale, duplication or gaps in service provision and to inter-professional rivalry and conflict (see Fried and Leatt, 1986), they also serve to resolve the tension between the need for a common identity and the need to embrace change. Their boundaries serve as filters, limiting accessibility thereby allowing members to retain a degree of control. The boundary is rarely static and in times of fear will become less permeable allowing miscommunication to occur, as individuals within the group become less receptive to outside interpretations of events. Williams (1998) notes that changing roles and identities in relation to boundaries cause uncertainty, which can both foster and threaten innovation and communication.

1.9 Sources of Stress among Nurses.

The defensive posture discussed above is both responsible for stress and serves to magnify the influence of other stress provoking factors. Blair and Littlewood (1995), for example, highlighted mistrust of other occupational groups among district nurses as well as ineffective communication networks, a lack of consultation and involvement in organisational changes, relationships with managers and the organisational structure to be stressful. Nurses felt suspicious of

managers` motives, information was withheld and nurses` work was not adequately understood or valued. Inglehart (1987) asserts that this stems from factors such as the "conditions… under which nurses must work – small financial rewards as compared with their responsibilities, limited autonomy in clinical situations, and little involvement in hospital management decisions regarding standards of practice…"

Changes in the traditional role of the professional are also occurring because of increased consumer awareness and health care targets (Brechin, Brown and Eby 2000). Tensions arising from responsibility and accountability within an era or resource constraints were also raised by ward sisters in Bowman's (1995) study, who commented that "we have the responsibility and accountability to ensure resources, but no authority to ensure their acquisition" and further, "it is difficult to ensure high standards of care without having control over resources, staffing and materials".

Bowman (1995) found that one of the key causes of stress was increased workload. In particular, stress is more likely to occur when multiple demands are made on nurses by medical and administrative staff and that structural characteristics of hospital units are also important in exacerbating or ameliorating levels of stress. Bowman's (1995) study showed that medical nurses experienced the highest levels of stress related to the wide variety of patients encountered and ambiguity in their treatment.

Many ward sisters also voiced concern over the transfer of patients inappropriately to their wards because of bed shortages. Nurses felt that they could not provide adequate care for such patients, especially if they needed emergency treatment (Bowman 1995, p.2). This was also the finding of Allen (2001) and Laurent (2001) who claim that senior nurses are "facing high levels of stress caused by staff shortages and `bed-blocking` by elderly patients…which they identified as a bed management problem beyond their control".

Bowman (1995) also notes that sisters and staff nurses found it difficult to ensure high standards of care for patients generally. They cite inordinate administrative workloads,

poor staffing levels and a dependency on many untrained or agency staff. "… when ward sisters (n=21) and staff nurses (n=74) were asked to what extent they could ensure safe standards of practice, 52% and 51% respectively, stated that they could not do this completely. Bowman tabulates the common areas of stress that ward sisters encounter (Table: 2.1) below.

Table: 1.2. Source, Frequency and Intensity of Nurses` Stress (from Bowman 1995, p.103).

Source.	Frequency.	Intensity.
Constant Interruptions.	Regular.	Very stressful.
Workload	Regular.	Very stressful.
Administration, paperwork.	Regular.	Stressful.
Conflicting demands.	Regular.	Stressful.
Multiple responsibilities.	Regular.	Very Stressful.
Inability to meet some responsibilities, e.g. safety of patient.	Regular.	Greatly stressful.
Poor working conditions.	Often.	Stressful.
Inadequate information.	Often.	Stressful.
Being kept informed by management of new events and change.	Often.	Stressful.
Lack of feedback on performance.	Regular.	Stressful.
Lack of authority.	Constant.	Stressful.
Lack of autonomy.	Constant.	Stressful.
Little job satisfaction.	Constant.	Stressful.
Low morale.	Constant.	Stressful.
Lack of support.	Constant.	Stressful.
Lack of resources.	Regular.	Very stressful.
Use of agency nurses.	Regular.	Very stressful.
No control over resources.	Regular.	Stressful.
Many consultants servicing ward.	Regular.	Stressful.
Inability to nurse patients because of administrative duties.	Regular.	Very stressful.
Not always able to do things properly.	Regular.	Very stressful.
Lack of opportunity to give individualised care.	Regular.	Very stressful.
Variety, brevity and fragmentation.	Regular.	Very stressful.

The responses from junior staff were more extreme citing lack of support, "being thrown in at the deep end" and worrying whether things have been done properly. They also felt that their education and training had not prepared them for the role that they were expected to assume (see also Allen, 2001). Although nurses are arguably the most visible occupational group, they are not the only group to suffer from stress, nor are standards of care and morale the only yardsticks whereby poor organisational performance is measured. Indeed, time pressures and financial constraints affect the organisation as a whole. McWhinnie et al (1994) assert that

such implications of, for example, cancelled surgical operations can be measured in terms of "loss of surgical workload and resources wasted". At the John Radcliffe Hospital in Oxford over a one-year period, the cancellation of thirty-six major aortic procedures resulted in a loss of £33,000 (see Table 1.3 below).

Table: 1.3. Resources wasted when 36 Major Aortic Procedures were Cancelled.
(After McWhinney, Michaels et al. 1994).

	Number.
Ward bed days.	78
Theatre time	65
Ancillary tests:	
Full blood count.	26
Creatinine and electrolytes.	26
International normalised ratio.	31
Liver function tests.	2
Kaolin cephalin clotting time.	11
Blood glucose.	10
Chest radiography.	5

1.10 Communication.

Given that the various occupational groups within the NHS are under increasing stress and given that this engenders a defensive posture in the individual, which is detrimental to good communication, this must have an effect upon the discharge planning process, which begins at the level at which health care professionals interact with patients and other staff. Bull (1994) examined patients` and professionals` perceptions of quality in the discharge planning process. She found that both users and providers rated good communication highly as a prerequisite of effective discharge planning. Effective communication was seen to have three elements; asking questions, obtaining answers, and having the ability to question inconsistencies. However, in another study (MacKay, in Soothill, Henry et al 1992) found that approximately one quarter of doctors and social workers believed that patients and families should assume the responsibility for asking questions and providing the staff with information. Nurses and the majority of social workers stated that they needed to ask questions of the patient since not asking questions was cited as an indicator of poor outcomes. As Bull (1994), however, points out, patients may simply forget the information or may not realise its importance. Nurses and others must therefore be taught to ask questions that enable them to

discriminate between information that has a direct bearing on therapeutic outcome and that which is unimportant. Adjaye (2003) also notes that improvements need to be made within and between agencies to the manner in which information is exchanged and that staff must be made accountable since "effective action... depends upon sharing relevant information on an inter-agency basis" and further:

> *"Information systems that depend on the random passing of slips of paper have no place in modern services. Each agency must accept responsibility for ensuring that information passed to another agency and the recipients should query any points of uncertainty".*

The consequences of poor communication were also evidenced by this same enquiry. One doctor commented "I don't think it was until I have read and re-read this letter that I appreciated quite the depth of misunderstanding". A social worker commented:

> *"... we have this huge chronology of information made available... its very frustrating... a pattern of things emerging, but knowing that at the time...separate agencies held those bits of information. So GPs will be seeing things, accident and emergency will be seeing things, the police may be dealing with other aspects...and nobody is bringing it together".*

This drift is cumulative in its effects and can be caused by poor record keeping by social workers, by nurses, overcomplicated and collateral administrative systems, confusion concerning managerial responsibilities, improvised arrangements for information handover and lack of supervision. As a staff member commented "...there were just too many routes and locations in which files could be lost". The enquiry concluded that nurses observed incidents but did not bother to record them, recorded information was not shared and was kept in a number of different places, was passed verbally and not recorded, a "fundamental aspect of basic professional competence" and that there was no order in medical records. The authors note:

> *"verbal handovers and referrals, either face-to-face or on the telephone, carry with them a high risk of ambiguous transfer of information and the creation of a false confidence that actions have been understood and will be carried out. Such verbal exchanges alone, unsupported by clear documentation, undermine high quality care".*

1.11 Socialisation.

This apparent reluctance to ask pertinent questions and the tendency to wait for patients to supply pertinent answers, may lie in the way that nurses are socialised for, whilst Smith (1992) noted that patients were more likely to stress the affective component of nursing rather than technical competence above all else, Melia (1987) found that nurses themselves placed a greater importance on the possession of technical skills and knowledge. Nurses and students rated the high prestige technical jobs more highly than the more basic tasks. Indeed, Melia (1987) found that it was communicated to the students in subtle ways that certain things were expected of them, that they should ensure that all physical work was completed first and that speed in the completion of tasks was important. This orientation towards technical skills and knowledge is fostered through normative rewards (Schein, in Walsh and Ford 1989, Koch 1994) such as Wilkinson and Miers` (1999) distinction between "clean" and "dirty" tasks which, they assert, reflects society's taboos about the physical proximity of the body (see Sontag 1983).

Hence, in Melia`s (1987) study surgery, for example, scored highly in the students` ratings. Geriatric wards and medical wards were cited as being areas where basic nursing care was carried out, or social arrangements made - not real nursing (see also Smith 1992) reflecting the influence of nurse socialisation. Students in Melia`s study were equally disparaging of older people claiming that, as bed blockers, they took up valuable space, depriving patients of a bed when other patients needed real medical and nursing care.

1.12: Medical Staff Perceptions of the Nurses` Role.

The notion of competence also emerges in the relationships between nursing and medical staff. The good nurse is often defined by nurses as taking the time to listen, communicate and be sensitive to the needs of patients. A significant number of nurses, therefore, see the most important elements of their role in terms of personality characteristics. The doctors, however, see the nurses` role as being one of assistance to the doctor. The doctor may, therefore, value competence and initiative as more important than personality. Within the current economic climate

there is a trend to expand the role of nurses to provide cost savings. White (2000) notes that economic expediency militates against collaboration and multidisciplinary teamwork and that the difference and complementary nature of the roles should provide the foundation of the debate. White, however, then asserts that the old medical ethos is still present. He states that he "expects nurses to do the things I dislike doing, cheaply and more efficiently". Furthermore, Walby and Greenwell et al (1994) note that the image of handmaidens is related to task priorities.

The apparent superiority of doctors also appears to be supported by Moores and Thompson (1986) who found that patients still perceived that nurses treated doctors as superior. Concerning the amount of information given about discharge, 44% of patients felt that they did not have enough input in this area from the medical staff. The assumption on the part of the patients is plainly that the doctor will visit them and divulge this information before they leave hospital. Doctors themselves, however, leave this to the nursing staff. Walby and Greenwell (1994) term such situations "conflict over task priorities" (see also Roskill 2000), which lead to unproductive duplication. Nurses clearing up after doctors, for example, was reported as a source of conflict by 79% of doctors and 82% of nurses.

1.13: Organisational demands and the sublimation of the caring discourse – conflict in the role of the nurse.

The evidence suggests then that conflict arises because of poor comprehension of other roles, mistrust of other occupational groups, manipulation of access criteria and workloads as a consequence of poor understanding of discharge policy and a defensive posture, which limits communication and interaction both between occupational groups and between occupational groups and service users. This is further engendered by subtle drives to socialisation. This has implications for nursing practice since, although nurses would appear to value affective components of their role, they act in ways which minimise this aspect of the care they provide. Although this section may seem tangential to the debate concerning the current effectiveness of the discharge planning process, its importance cannot be overstated. This section is an attempt to describe why occupational groups (with

particular reference to nurses) behave as they do when faced with the conflicting demands of profession and organisation. That this, behaviour has profound effects on the discharge planning process and, therefore, upon service users will be demonstrated below. The sublimation of the caring discourse into a tool to resolve these conflicting demands leads to stereotyping, increased patient dependence, poorer care outcomes and, ultimately, to increased length of stay and risk of readmission as an emergency.

Sines (1994) asks how individuals act in ways that are contrary to standards espoused by the profession they represent. Menzies (1970) lists nine "social defence mechanisms" which she suggests aid staff in periods of uncertainty and threat. The key defence strategies are: a "splitting of the nurse - patient relationship", "depersonalisation and categorisation of the individual", "the attempt to eliminate the need to make decisions by ritual task performance" and finally the "avoidance of change" (Chapman 1983). This is supported by Reynolds and Scott's (2000) assertion that because of constraints that exist within health care organisation, the affective component of the nurse-patient interaction is removed and the humanity of employees is blunted. Furthermore, Moores and Thompson (1986) note that task allocation and nurse workload, as well as unwritten rules concerning socialisation, are highly detrimental to the nurses' ability to sustain meaningful informal relationships since service users are also expected to conform to rules whilst on the ward. Moores and Thompson (1986) found that the majority of the patients either agreed or agreed strongly that there were a number of tasks to be performed by the nursing staff and the patients had to fit in to the nurses` schedule

Stereotypes also arise from the nurse patient relationship which defines who is and who is not a patient and, therefore, who is deserving of treatment and who is not (see also Kelly and May 1982). Further evidence suggests that nurses and patients disagree about patients' functional ability, with nurses underestimating this (Reiley, Iezzoni et al 1996).

Stereotypes, together with specialised language use and gossip, form part of the socialisation of nurses (Payne, Hardey and Coleman 2000). Furthermore, Payne, Hardey and Coleman (2000) found that utterances indicating that patients` status

was unchanged had little to do with judgements concerning pathology and more to do with the perceived amount of nursing input required. This supports assertions that patients may be considered deviant when they become too demanding (Kelly and May, 1982). The desirability of throughput was also evident in nurse handover by references to discharge. There were, however, few references to patient status or social factors. Time and organisational pressures reduced the group conception of the patient to a disease entity described in biomedical terms, whilst alternative models that emphasised the psychosocial caring discourse rather than the biomedical were effectively smothered because of subtle agendas dictated by profession or organisation.

Melia (1987) notes further that unwritten rules remained unwritten precisely because their formalisation would reveal that nursing was thought of in terms of workload and this is incompatible with the professed ethos of nursing in which the dominant discourse is one of caring. She also notes that because nursing is construed as "work to be done", a tension is produced between the idealised and the practical. Melia concludes that nurses are often unclear about the ideal standard of practice to which they should aspire and that a number of nurses find difficulty in achieving consonance between professional standards and the standards they achieve in practice.

As an example from another field, James (in Robinson, Grey and Elkan 1992) examined the attitudes of hospice workers and found that because of the routinisation necessary in such organisations there was a mismatch between the level of care that could be given and the idealised amount. Thus, care degenerated in to a series of tasks (work). The two became fused into the concept of "carework". Nurses, therefore, profess ideals that are morally worthy and are also congruent with the wishes of the service user as enshrined within the mutually held folk definition of the professional. Moreover, Becker (1962 in Melia 1987, p.145) argues that the layperson's use of the term "professional" denotes a "folk concept", serving as a yardstick to measure not how occupations are, but how people believe they should be. As Walby et al note (1994) task definition and allocation by nursing staff serves to mask relational and territorial disputes which may compromise the working of effective teams. This in turn means that the service

user becomes of secondary importance as the reduction of carework to a simple routine causes both patients and nurses to conform to a set of rules, which blunts the affective relationship and causes patients to be seen as disease entities rather than individuals.

Lauri and Salantera (1998) concluded that decision making models used by nurses in different fields fell into one of five categories. They note that in long-term care the decision making model used was rule orientated and emphasised the relative importance of the nurse and the nursing process when compared to other settings which were more patient centred and intuitive. Rule orientated behaviour patterns serve, therefore, to increase patient dependence through the labelling of deviance. The consequences of this phenomenon for the discharge planning process are discussed in the following sections.

1.14 The consequences of nurse socialisation and perceived patient deviance.

Walsh and Ford (1989) assert that hospital nurses discharge patients with varying degrees of insight in to the support services available to older people in the community. Furthermore, Waters (1987) notes that levels of functional disability in the performance of Activities of Daily Living in members of the sample population was greater following hospitalisation. This may be because nurses and patients placed different emphasis upon functional, informational and environmental needs with nurses underestimating the needs of patients in a number of key areas. Concerning information on discharge from hospital, for example, whilst 35% of nurses felt the information provided was insufficient, the figure for patient estimation was 71% (Lauri, Lepisto and Kappeli 1997).

These concerns are supported by a study conducted by Breemhaar, Visser and Kleunen (1990), which compared perceptions and behaviour among differing age groups of hospital in-patients and found that, when compared to younger patients, older people were less likely to complain, showed fewer emotional problems, were less likely to ask questions, discuss problems, or engage in self care. Despite the fact that the authors also noted that older people were more likely to give socially desirable responses, the lesser levels of complaint were also taken to mean that elderly patients exhibited

stronger feelings of powerlessness. Miller (1985) examined the effects of patient dependence on geriatric wards that used task allocation and on those that also gave individualised nursing care. She found that nurses would routinely carry out tasks for patients rather than wait while the patients carried out the task for themselves which meant that patients remained in hospital for more than one month fared less well on wards which were defined as traditional compared to wards which provided individualised patient care. She noted that patients "are significantly more physically dependent; they are more apathetic, they have more communication difficulties and their information/orientation scores are lower than similar patients in wards using individualised care". She concludes, finally, that patients stayed longer in the traditional wards (i.e. they were less likely to be discharged), and more died there.

Two other facets of patient discharge are medication education and patient falls. Medication discharge education (MDE) is especially important in the light of Ford's (2001) findings concerning polypharmacy in older people, which showed that side-effects were poorly understood by patients and that the risk of falls was significantly increased. This is supported by both Rycroft-Malone et al (2000) and McGraw and Drennan (2001) who also suggest that medication error is a significant factor in readmission to hospital. Rycroft-Malone asserts that client education by nurses falls far short of expectations and is comprised mainly of information giving on the day of discharge. McGraw and Drennan (2001) claim, however, that although there are a number of home-based strategies that can be used to promote compliance, none of these methods are entirely free from error.

Both studies indicate that the best method of achieving optimum medication compliance among older persons is by introducing adequate multidisciplinary assessment and a formalised education strategy rather than simple giving of information. Reiley, Iazzoni et al (1996) showed that nurses believed that ninety-five percent of patients understood the side effects but that only fifty-seven percent of patients claimed they understood. McBride's (1995) study also indicates that not enough information is provided to GPs and other members of community teams regarding discharge arrangements generally and significant numbers of patients and carers felt they were not informed at all regarding arrangements made. This is despite the fact that the above studies indicate that patients and carers valued MDE,

especially when the information was individualised, given orally and reinforced with written documentation.

Reeson and Wafer (2001) found that falls increased when activity increased, that the majority of the fallers lived alone and that the vast majority of falls were classified by the client as either slip/trip or collapse. Although medication history was obtained in only thirty-four clients, twenty-one were taking at least three or more medications, which are associated with increased risk of falls. A further four clients were known to have had falls directly related to medication. Of the patients who collapsed, the authors note that sixty-nine remained undiagnosed and uninvestigated on discharge (see also Lewis 2000). Their recommendations are that specialist teams of personnel (including gerontologists) should instigate considerably more thorough assessments of older people at an earlier stage in the clients` hospital career. This echoes Kibbler`s (1997) suggestion that this population would benefit from specialist intervention although Herbert et al (2001) found that nursing intervention designed to prevent functional decline in older people regarding falls and medication compliance was ineffective.

1.15: Readmission to secondary care.

Regardless of efforts to plan discharge effectively and educate patients regarding medication, there will always be some patients who are re-admitted to secondary care, some of which are avoidable. For example, of 170 referrals from GPs to hospital doctors during a six-month period, 58 were avoidable (Elwyn and Stott 1994), of which 32 where judged to have arisen because of insufficient resources. Of these 32, ten were judged to have occurred because the hospital staff failed to pass on information to the GP concerning a previous referral or contact. A further nine were due to an incomplete primary health care team, which made referral to secondary care unavoidable and eight resulted from lack of direct access to facilities. Knowledge gaps were also evident on the part of some of the GPs. The importance of community resources is also highlighted by the advent of Hospital at Home services (HAHs). In a research briefing by staff at the John Radcliffe Hospital (1997) it was claimed that 260 patients received intravenous antibiotics at home, saving 6,033 bed days. All studies highlight the need for effective, individualised assessment before discharge.

Readmission to secondary care not only results from inappropriate admission from GPs but also arises from closure of care homes. Bunce (2001) notes that "40,000 out of 570,000 beds in care homes have been lost over the last five years" and that in the year 2000, eight hundred residential and nursing homes were forced to close which denied an already overstretched sector of approximately 15,000 beds. Again the lack of community resources and the possible failure to meet the educational needs of staff within these establishments may contribute to the unnecessary admission of vulnerable individuals to hospital. The exact nature of these shortages in equipment and education are summarised in Table: 1.4 (below).

Table: 1.4. Additional resources identified by residential and/or nursing homes to prevent hospital admission. (After Read 1999).

Resources required	Percentage of respondents	Type of home
Equipment, for example, infusion poles.	83.3	All types
Multidisciplinary services	37.5.	DH and RH.
Expanded skills / policies to support cutaneous therapy.	12.5.	DH and NH.
Expanded skills / policies to support intravenous therapy.	12.5.	DH and NH.
Skills/training, for example, phlebotomy,	12.5.	NH.
General advice via the telephone.	12.5.	RH and NH.
Anaphylaxis training.	6.2.	DH.
DH = dual registered homes, RH = residential homes, NH = nursing homes.		

Legge (1999) highlights a series of statements by nursing home staff, most of which are concerned with the grading system by means of which social services departments classify the type of post-discharge care that is needed. There were a number of incidents whereby individuals who needed intensive nursing care were classed as suitable for residential homes. As Legge (2000) points out "there is clearly something wrong with a system that classifies a 60-year old woman who weighs 4st 4lb, has chronic obstructive pulmonary disease, and needs oxygen therapy and a nebuliser every four hours, as not in need of nursing care". He further points out that although social work assessments were seen as instrumental in propagating this state of affairs, there was a widespread acknowledgement of the "budget driven" nature of the problem. Ford (2001) asserts that there is a major under funding of NHS input to homes of all types

and claims that people in these homes do not have access to the same level of care as their compatriots in the acute sector.

Other reasons for readmission to the acute sector included unresolved chest infections and dehydration or a change in the client's functional ability, which meant that the person was no longer judged to be appropriate for a residential home. There are also instances of readmission to the acute sector to provide terminal care at the insistence of the GP or the person's family and despite the recommendations of the other staff. None of the staff in the homes accepted the diagnosis and treatment of infections, assessment following falls and fractures, or psychiatric treatment and assessment as warranting admission to the acute sector although a large percentage of homes had experienced the use of these criteria to admit patients to hospital. This may be entirely consistent with Read`s (1999) findings concerning the control exerted by GPs and relatives in deciding the next step in a patient's medical career. Further, whilst none of the home staff identified admission to hospital for rehabilitation as something their patients had experienced, it was given as an appropriate reason for admission by twelve percent of homes. This indicates the immense pressure on rehabilitation beds, since homes see it as a valid reason for admission but perhaps bed space in this area is at such a premium that no person resident in a home can be admitted to the acute sector to receive rehabilitation.

Both the Audit Commission (2001) and the RCN (2000, a&b) note that rehabilitation services and skills are crucial in reducing both the pressure on nursing and residential homes and readmissions to the acute sector. The Audit Commission (2001) points out, however, that services are variable. Its findings were that the number rehabilitation beds varied between areas by a factor of five, therapy time per bed varied from a few minutes to nearly one hour per day and that only one third of areas have multidisciplinary teams to support people at home. The commission also notes that joint, comprehensive assessment is essential and that therapists need to be used effectively. Finally, it notes that a significant number of areas lack facilities like step-down areas despite their perceived effectiveness (Woodcock 2001).

It is evident within the literature that poor discharge arrangements have serious consequences for subsequent home care interventions. The NHS Quarterly Review for the period July – September 2000 (DOH 2000) notes that 7.1% of "elderly patients" were readmitted to hospital within 28 days and 13% of elderly patients were reported as being delayed discharges (see also NAO 2003). In the period 1996/7 Age Concern reported that 86,000 people aged 75 and over were readmitted as emergencies within 28 days of discharge. The Audit Commission (2001) asserts that home based intervention of nurses and pharmacists reduced the frequency of hospital admissions and out-of-hospital deaths after discharge. Pearson, Luke and Horowitz (1998) and Naylor, Brooten et al (1999) assert that discharge planning and home follow-up by an advanced nurse practitioner reduced costs, readmissions and the length of time between discharge and readmission. Shepperd and Iliffe (1998), however, report that care delivered at home does not improve patient health outcomes. Indeed, although terminally ill patients reported greater satisfaction with "home based care" at one month, this level of satisfaction had decreased by month six and carers also reported decreased satisfaction. The above studies indicate that the effectiveness of home or community based interventions is not certain.

Furthermore, in three of the four studies above effectiveness was measured solely by quantitative markers. Only in one of the studies was satisfaction used as an indicator of effectiveness. This suggests that qualitative elements of good discharge (such as informational, educational or counselling needs) are being overlooked at the expense of those elements, which are predicated upon throughput. The above studies suggest further that generalisation about the type of intervention required may be fruitless and that patterns of intervention should be tailored to individual needs and take account of both qualitative and quantitative needs of those involved. Finally, home and community interventions will be less effective if poor planning in hospital means that people are discharged in a state of unreadiness.

Idris-Williams and Fitton (1988) undertook a study involving 133 patients most of whom were aged 70 to 79. They assert that unplanned readmissions occurred because of failure in communication between hospital and community services causing dissatisfaction among those involved. Discharging people too early was a common precipitator of problems. The factors influencing readmission are given in

Table 1.5 (below).

Table: 1.5 Principal and Contributory Factors in Unplanned Hospital Readmission

(After Idris-Williams and Fitton 1988).

Reason for Readmission.	Contributory in: Number (%). Number = 133 unless stated.	Principal in: Number (%), (n=133).
Relapse of initial illness.	67 (51).	18 (14).
New problem developed	20 (15).	4 (3).
Carer problems.	19 (14), (n=100).	83 (83).
Complications of initial illness.	7 (5).	1 (1).
Terminal care.	8 (6).	0 (0).
Medication problems.	8 (6).	39 (29).
Problems with services.	4 (3).	24 (18).
Discharged too soon: Opinion of carer or patient.	77 (58).	
General Practitioner's opinion.	26 (31). (n=83).	
Lack of information from hospital to GP	49 (47), (n=104).	
Living alone.	57 (43).	
Poor health on discharge, opinion of carer or patient.	49 (37).	
Inadequate preparation for discharge.	49 (37).	
Incontinence urinary and faecal.	44 (33).	
GP`s failure to visit	15 (11).	
Very confused: opinion of hospital or patient or carer.	13 (10).	
Discharged self.	2 (2).	

The consequences of poor discharge arrangements not only affect patients but also their carers. The Carers` National Association (CNA) found that carers are failed by services both on discharge from hospital and once they are resident in the community. Ninety percent of carers felt that their relative had been discharged too soon (Holzhausen, 2001). There has been a fall in the number of carers who were consulted and the number of carers who were given a written copy of the discharge arrangements. Still, pressure to discharge people from hospital produces adverse consequences for patient and carer alike and few hospitals have formalised mechanisms where the views and informational and emotional needs of the carers are taken into account despite the well documented need for this (see Jackson

1994). Bruster, Jarman, Bosanquet et al (1994) carried out a survey of 5150 patients in 36 NHS acute hospitals. Twelve percent of patients did not have the reason for their hospital admission explained to them, ten percent of patients experience differing information regarding the same subject from doctors and nurses, 44% of patients did not have any discussion with their doctor regarding discharge. Seventy three percent of patients were not given dietary advice regarding which foods to eat or abstain from, 60% were not given information concerning prohibited activities, 62% were not told when it was safe to resume normal activities and 28% felt that their relatives or carers were not given sufficient information. Information exchange was generally felt by patients to be adequate but a significant number felt that they had to prompt nursing staff for information.

Informing patients that they are ready for discharge has also been the subject of a study by Moores and Thompson (1986), who found that the majority of patients were notified between a few hours and a day before of their impending discharge, the majority were left to make their own arrangements regarding transport home, most of the patients were given advice about what they should and should not do at home and in the vast majority of cases this was given freely, without prompting. Overall the vast majority of patients (approximately 60%) thought discharge arrangements were as they expected. Fairhurst, Blair, Cutting et al (1996) found that 80% of patients felt that they had been adequately consulted about their discharge. Moores` study did not follow patients up post-discharge whilst Bruster, Jarman, Bosanquet et al did. This may account for the more extreme responses generated in the former study. Boyle, Nance and Passau-Buck (1992) also note that patients are concerned with resuming activity and medication information and side effects and notes further that since patients are now being discharged from hospital at a faster rate proactive, anticipatory discharge planning should be routine.

Failure to meet informational needs leads to increased rates of readmission as supported by the CNA document and the Government's own Hospital Episode Statistics (HESs). Staniszewska and Ahmed (1998) conclude that although many patients are aware of the current context in which nurses must work, they still expect that nurses will be their advisor and advocate and although this happened in the majority of cases there were occasions where nurses` communication skills were

thought to be less than adequate. The National Audit Office (2003) notes that there is an inherent tension between the need to reduce delayed discharges quickly and the wider Government objectives of maximising independence through the diversification of service provision, what Bull (1992) characterises as helping the patient and family unit achieve mastery through coping mechanisms.

Discharge arrangements have also been found to be too complex for carers (Sutherland, 1999) to the point of being bewildering and incomprehensible, with the locus of control moving away from carers. Furthermore, the emphasis on residential care meant that the concept of prevention and rehabilitation was being sacrificed in order to cut costs. Sutherland's report also identified that the lines of responsibility between health and social care were unclear with number of perverse incentives within the system making the short-term view more attractive based on costs alone.

Overall, the evidence suggests that patients remain confused concerning the number of staff who are involved in their care and the fact that contradictory information is received by patients from different members of staff. McSherry (1996) contends that the ideal method of optimising information flow would be through a ward-manager led model indicating that the locus of control has shifted from those staff who are in continuous close proximity to the patient. Meddings and Perkins (1999) note that whilst the roles of the individual members were appreciated by the patients, their concept of the composition of the team was less accurate. They also note the service users` subtle use of language in terms of simply talking or language used to elucidate symptoms, seek advice, or discuss sensitive issues. This suggests that nurses are unaware of and do not act upon cues concerning what type of language game is being engaged in by the patient. This may compromise both the accurateness of the assessment and the depth and veracity of the therapeutic relationship (see also VanCott, 1993).

The Health Advisory Service (1999) found that there were problems at all levels of the system including shortages of equipment, insufficient staff, insufficient training and difficulties in the co-ordination of an effective discharge planning service. Houghton, Bowling et al (1996) note that there was considerable room for

improvement in the discharge planning process and point, in particular, to delays whilst social service input is arranged and delays in obtaining medication from pharmacies.

In an attempt to ensure a seamless transition through the various stages of care, the Government intends to levy fines from Local Authorities for each person who becomes a delayed discharge. Herbert (2002) engaged in a simulation exercise with interested parties in an NHS Trust. This strategy, far from driving improvement, will result in a number of perverse incentives to discharge people both too soon and to inappropriate surroundings. Furthermore it will damage the already strained relationship between Local Authority staff and acute care staff. Herbert found that the participants had grave concerns over a number of issues and they are given verbatim in Table 1.6 (below).

Table: 1.6 Perceived Negative impact of the reimbursement policy (after Herbert 2002).

There is a great potential for conflict between organisations and practitioners arising from the introduction of reimbursement
Without changes in current partnership arrangements, the Local Authority could experience serious financial pressures and quickly become unable to meet current commitments for older peoples` services
It was felt by some that acute Trusts would have little incentive to work in partnership in the short term and would see financial gain as a positive incentive to claim people were fit for discharge too early, without taking any responsibility for planning or arranging support following discharge.
The policy could rapidly lead to further increases in delayed discharges and Local Authorities attempting to transfer more responsibility for community services to health
The policy would be likely to detract from the development of appropriate alternatives to hospital admission with Acute Trusts encouraging more admissions.
Serious threats to investment in alternative community services to facilitate discharge were perceived as likely to arise from the payment of fines.
Interest of users and carers were unlikely to be served if agreement on approaches was not reached by partners. This could well lead to increased litigation and formal disputes.

This method of attempting to ensure that delays in discharge are minimised would be damaging in the extreme. It is ironic that all talk of a blame-free and co-operative culture seems to have been forgotten here as the Government appears to

be blaming local authorities for an inability to act quickly following years of underinvestment.

1.16 Summary.

The initial literature review indicates that the problem of delayed discharges is exacerbated by increased pressure on hospital beds, perceived lack of resources and lack of support. Such pressures and the consequent stress placed on occupational groups causes uncertainty and conflict leading to defence mechanisms, which militate against flexibility and cross-boundary working because of maladaptive communication practices. The roles of the various members of the multidisciplinary team are poorly understood and organisational demands come to take precedence over the need of the patient. This leads to poor assessment, incorrect assumptions concerning functional ability and needs and the subversion of the caring discourse which places vulnerable individuals at risk of untimely emergency readmission.

In the following chapter, the philosophical basis of the study will be discussed, as will the methodologies, methods and types of instrumentation used in attempting to examine some of the assertions made by authors cited above and to test their validity within the setting in which this study was carried out.

Chapter Two: A justification of the methodology, methods and instrumentation used in the study.

The preceding chapter provided an initial examination of key themes within the discharge planning process. In this chapter the chosen methodology will be defined and its implications for the study will be discussed. Also the discussion of specific methods of data collection and instrumentation used in this study will be undertaken as well as a discussion concerning those strategies which were used to ensure the validity and trustworthiness of data. Finally, ethical dilemmas and their implications will be discussed before offering any necessary concluding remarks.

2.1 Definitions of ethnomethodology.

Phillips and Phillips (1998) discuss interpretations of the history of immigrants to the United Kingdom. They note that:

> *"All this is mistaken, and spotting these mistakes is crucial because, if you are working from a crude distortion of the facts, it becomes impossible to approach any true understanding of what happens next. This, in its turn, makes it very hard to arrive at sensible decisions about your current identity and direction. Another problem is that distance imposes a generalised identity on disparate groups, muddles one happening with another, lumps opposed individuals together on the basis of superficial resemblances, and assumes that discernible emotions and attitudes were the same thing as the motivation behind events. It is healthy to regard with suspicion any narrative which ties the past together into a rational and coherent account...because the truth is that people cannot help reshaping history according to their own needs as individuals and according to the needs of the time".*

This statement contains the key principles of ethnomethodology emphasising that cultural, contextual and historical factors play a key part in the shaping of reality and, furthermore, that individuals seek to use their own interpretations of reality to structure their social environment and give meaning to social interaction in a manner which enables them to control that same social environment. Thus, reality is constructed, produced and continuously updated and maintained by the interaction between social actors as reality constructors. Manias and Street (2000) define ethnography as a methodology in which researchers "value the history of the

setting and recognise the politicised nature of relationships between co-researchers. They note that this process allows communicative practices and reflection by means of which truth of a culture may be arrived at (see also Holland, 1999; Payne, 2002; Maggs-Rapport, 2001; Tutton and Seers, 2004). Porter and Ryan (1996) argue that in nursing research ethnography may reslove the apparent tension between social systems and individuals by enabling nursing research to give due attention to both. Ethnography, they argue, works under the assumption that the relationship between social structures and individual actors involves a two-way process, in that while the enablements and constraints imposed by structures influence individual actions, those actions in turn either maintain or transform social structures. Savage (2000) notes that ethnography encompasses many methods and can promote satisfactory combinations of both the qualitative and quantitative paradigms. She notes further that:

> *"...the term ethnography can be applied to any small scale social researtch that is carried out in everyday settings, uses several methods, evolves in design throughout the study and focuses on the meaning od individyals` actions and explanations".*

Leung (2002) argues that ethnography allows the researcher to participate in the culture of the individuals being studied which, arguably, must occur before one can produce meaningful and, therefore, valid explanations of a phenomenon.

Garfinkel (1967) notes that members within particular social settings manage those settings and make the settings accountable to others (intersubjectivity). The management of settings is ongoing and is contingent upon practices of accountability, which precede and follow them (seriality). Such social acts are reflexive because, in the act of describing and making accountable, organisation occurs and this organisation is dependent upon knowledge and skills that are held by social actors thus furnishing that setting with context. The reflexive nature of language as a mediator of human interaction in the description and, therefore, the manufacturing of reality entails that certain propositions are held concerning language use. Garfinkel (1967) lists the following:

- Firstly, that "the definite and sensible character of the matter being reported is settled by an assignment that reporter and auditor make to each other that each will have

furnished whatever unstated understandings are required. Much, therefore, of what is actually reported is not mentioned". This is a statement of the supposed fact that much of the social knowledge upon which shared understandings concerning reality are based is tacit knowledge. Inasmuch as this tacit social knowledge permits discourse between individuals in the construction and maintenance of reality it is also shared knowledge. This has important implications for communication between health care professionals and between health care professionals and service users. If one includes other assertions concerning the nature of the construction of social knowledge then this will become more obvious.

- Secondly, Garfinkel notes the importance of "seriality" in interaction. The import of social interaction only becomes fully clear to the participants over the time it takes to complete the interaction. Each speech act is, therefore, dependent on the speech act, which follows it in order that it will become intelligible to the parties concerned. As well as seriality and the prior understandings concerning the use of and meanings of speech acts that individuals bring with them to each new context, sense also accrues to these accounts by organisational occasions of their use.

- Thirdly, social knowledge is important in that it is a means of influence within the world. Social competence is directly proportional to the amount of social knowledge one possesses.

The implications for the study are that the discharge planning process entails the co-operation of numerous individuals to ensure the desired therapeutic outcome. Examination of relationships between professional groups may reveal that they share a common stock of knowledge and orientate themselves to it when constructing reality through interaction.

Such different orientations towards the discourse of healing may arise as a consequence of professional socialisation, subjective interpretations based upon previous experience and the response of individuals to current interactions. That is how they revise the insights gained and immediately use them through the medium of language to construct a social reality.

Specialised language use is also important in this regard. Language, which may not be comprehensible to members of other occupational groups, may hinder communication but further, specialised language use among certain groups presupposes (if one accepts the tenets of ethnomethodology) that members of those same groups share a reality that is roughly consonant. That is, in sharing the same stock of knowledge intersubjectivity becomes possible. If contextual influences are also considered, it may become apparent that miscommunication does not simply arise from non-implementation of policies or from apathy or lack of time. Problems with communication arise because various occupational groups construct reality differently. Communication may, therefore, be part of a deeper problem and not simply be due to structural and procedural inadequacies within the organisation. As a consequence one may be able to state that, although these structural/procedural barriers to good communication deserve attention and should be rectified, simply attending to procedural aspects will mean that problems continue. This study attempts to delineate some of the conceptual processes that influence practical action or "situated activity" (Layder 1997).

2.2 The role of the researcher.

The suitability of a given methodology lies in its applicability and expediency in generating data that seeks to test the hypothesis or provide answers to research questions. If this is the case then the question that must be answered concerns the exact relationship between researcher and participants (co-researchers).

They are:

- The relationship of the researcher both to the phenomenon being studied and to the participants.
- The relationship of the participants to each other in the context of the phenomenon being studied, and finally
- The interpretation of the phenomenon by both the researcher and the participants.

Schutz (1994) suggests that nurse researchers approach the research situation with a particular manner of seeing things, of recognising the dualism between researcher as observer and researcher as participant (Manias and Street, 2000) and of interpreting

research findings in an idiosyncratic manner. It represents the personal manner in which a person relates to and conceptualises an external reality. Subjectivity, therefore, may be said to assume that multiplism is possible but generally states little concerning how such interpretations are intuited or the manner in which this ordering of reality is conducted. As an example Pierson (1999) points out that traditional nursing theories have tended to be subjective but within the framework of objectivity. Thus, whilst there may be an assumption uncritically accepted, that subjectivity promotes understanding of individuals through reflexive practice this may not always be the case. As well as the subject-subject relationship that may exist it may be possible, particularly within the context of health care, in which such a nexus becomes subverted in to a relationship between subject and object. The reduction of patients` behaviour to "measurable, observable commonalities" was the result of the attempt to engage with individuals within the context of medical rationalism and positivism.

Rather than the traditional distinction between the researcher and the respondent ethnomethodology stresses the importance of the role that co-researchers play. In this regard, ethnomethodology is superior to the classic ethnographic studies such as "The Golden Bough" (Frazer 1993) or Evans-Pritchard's (1976) "Witchcraft, Oracles and Magic among the Azande". These works are the result of the dominance exercised by the researcher, a dominance that did not allow an exchange of ideas and an acknowledgement of a number of possible interpretations. Ethnomethodology, on the other hand, recognises the key role played by the "participant" or "co-researcher" and acknowledges the fact that participants engage in a constitutive manner with the researcher in relation to the phenomenon being studied. They are part of the phenomenon and the manner in which the respondents react to and interpret the nuances of the phenomenon as manifest in their daily lives and social relations can significantly alter the manifestations of that same phenomenon.

It is important also to recognise the limitations of a purely subjective approach by the researcher (the dangers of interpretative bias and disempowerment). Equally important, however, is an awareness of the need to acknowledge the fact that complete objectivity is neither possible nor desirable in research that has as its main focus the situated individual (see Schutz 1994). Hermeneutic experience (Koch 1994) provides a means by which all possible interpretations of the phenomenon can be explicated and

examined whilst at the same time acknowledging the unique individual experiences which are brought to the programme by the participants and the manner in which such experiences both constitute and are themselves constituted by social reality. This mutual engagement is termed intersubjectivity. In this regard, ethnomethodology exhibits some similarities with phenomenology, in which meaning is sought through individual narrative. Ethnomethodolgy also seeks the consensus of intersubjectivity and can be utilised at the level of the individual. It goes further, however, in seeking not just individual narrative as an explanation of social phenomena, but seeks to explain the social construction of reality in all its forms since all forms are a part of the social construction of reality. Ethnomethodology, therefore, operates not just at an individual level but also at the level of systems or organisations and must, therefore, subsume documentary evidence, critical incidents as well as individual narrative in order to fully triangulate and explain the relationship between individuals and the reality they construct. Ethnomethodology may, therefore, be thought of as phenomenology on a grander scale. Maggs-Rapport (2000) discusses the differences and similarities between the two methodologies .

In a more practical sense potential problems exist in the initial establishment and maintenance of field relationships Schutz (1994) notes that familiarity and role conflict influence the quality and duration of relationships and consequently the data obtained. Stinson-Kidd (1992) also notes that problems of familiarity can arise. Stinson-Kidd (p.500) notes that the attitudes of the staff towards her varied during the time she spent in an area where she normally worked. She notes that it was difficult to gain the support of the staff because:

> *"...the field worker violates two basic norms of intensive care nursing: do not sit down, and talking is not working. At stressful times on the unit, I was viewed (I thought) as a lazy non-productive intruder. I was accepted far more readily when I was in scrubs, the institutional attire for ICU nurses."*

A number of similarities with this account occurred whilst attempting to gain access to the field environment and engage the nurses and other staff. This, though, was dependent on context (see the section regarding the insider outsider continuum below). In areas where I was known to the staff and had worked with them the nursing staff

were willing and candid in volunteering information. This applied not just to the wards concerned but was mirrored between hospitals such that at Trust A I felt that the staff considered me an insider. At Trust B, however, with the exception of one ward that had previously been visited, the reception was more guarded.

As well as the sense of familiarity, which may be termed personal familiarity, there was also the question of familiarity of role. During data collection a nurses` uniform was worn. Because participant observation was used to generate much of the data I found myself forced in to a trade off between the desire to observe and collect data and the expectations of nurses that because of my role I was expected to share some of the work. The amount of work I was expected to complete varied depending on the speciality and the workload on the ward at the time. Thus, during busy periods data collection through observation was minimal.

I also found my familiarity with the role meant that on occasions it was all too easy to allow (though not consciously) the nursing elements to dominate. Some opportunities to generate data through observation were missed because I became so involved in nursing tasks. This is in part related to Schutz`s (1994) comments regarding familiarity in that becoming too involved in the minutiae meant that no observation was carried out. It also meant that a great deal of care was needed in the interpretation of data since on occasions I found that the analysis of data merely confirmed my own perceptions.

The question then becomes one of the transferability of the findings. This is the area in which conceptual familiarity needed to be guarded against. This was carried out by triangulation (discussed below). Another important method used as recommended by Koch (1994) involved analysing each transcript (discussed below).

2.3 Types of triangulation, their use in and implications for the study.

Shih (1998) defines triangulation as a process of "mutual confirmation" through completeness and notes that, rather than expecting multiple data sources to confirm one another, triangulation should be used to add additional facets to the explanation of the phenomenon, thereby cancelling the weaknesses inherent in each data set or method (Foss and Ellefsen, 2002). Denzin (1989) distinguishes three types of data (or data

source) triangulation. They are time, space, and person triangulation.

1. Data Triangulation.

This method of triangulation is further divided in to three sub-types. These are time triangulation, space or location triangulation, and person triangulation. These are discussed below.

a) Time triangulation.

Time triangulation involves collection of data concerning the same phenomenon occurring at different times. Its purpose is to test the congruence between the differing sets of data. This, however, does not have the same aim as longitudinal studies which, although data regarding the same phenomenon is also collected at different times, has as its objective the explication of changes in the phenomenon over time rather than their congruence. This method of triangulation was used in the study. The need to collect information from nurses over time and on different shifts, for example, bore a greater relation to the sampling methods chosen and the length of the study than the need to triangulate findings. This, however, illustrates a point made by Kirk and Miller (1996) that field studies have an inherent triangulative nature. By the very methods used in field studies (especially those which are grounded in a particular setting) triangulation will arise as a consequence of data collection methods used and the differing information supplied by participants. There is also, within ethnomethodology, the dyadic relationship between the researcher and participants, which allows at least some degree of triangulation to occur. Because it is the task of the researcher to seek out non-congruence, to welcome what Kirk and Miller (1996) call "anti-coherence", triangulation in some degree is almost bound to occur. This is not to say, of course, that the enterprise should be left to chance. The constant testing and questioning of emergent themes and hypotheses means that a high degree of congruence can be more certainly arrived at, that the trustworthiness of the data will be maximised.

b) Space or location triangulation.

Space triangulation involves the collection of data from different sites and is concerned also with validation of findings. This was used in this study at a number of sites. Staff of two large acute care facilities were included in the study as were staff of community based secondary care providers, which themselves were within the catchment area of one or other of the acute facilities. The study may thus be defined as being conducted on at least two sites, but depending on the definition of "site" which is used, could be said to embrace as many as ten. The purpose of choosing more than one site for inclusion in the study was to increase the degree of congruence of the findings. That is, the findings from each hospital would possibly be mutually supportive, thereby increasing the level of congruence and, therefore, generalisability. In choosing to triangulate in terms of space, however, two important steps were taken to assure that valid cross-site inferences could be made. The first step was conceptual in nature and principally affected the second phase of data collection; the second concerned the directedness of the data collection process in ethnomethodology and thus had implications for the sampling process as well as analysis of the data.

The first step was to acknowledge the assumption that because all sites were within the NHS, all cultures would be the same. This was particularly the case in phase two of the data collection process. Because comparisons were made between data already collected in phase one and phase two, it was tempting to interpret the practices of staff at Trust B using conceptual frameworks which properly belonged to Trust A. This was a type of fundamental attribution error in that unconsciously on occasions, the researcher began to explain the behaviour of staff in the Trusts studied in cross-Trust terms. Moreover, it was tempting to search for an essentialist explanation of behaviour, which, by divorcing such behaviour from its context began to undermine the constructivist philosophy of ethnomethodology and, therefore, the validity of the conclusions generated from the study. There was little action in terms of practical safeguards that could be used to combat this, yet this is an example of why other methods of triangulation discussed below became necessary to produce valid data and generate conclusions.

c) Person triangulation.

Person triangulation involves as Begley (1996) states: "the collection of data from any pair of the three levels of persons: individuals, groups and collectives." This method of triangulation was not used within the study, since it presupposes a level of intimacy between an individual and that same individual as a member of a group. Although members of groups were interviewed individually and some of those same members were interviewed in a more ad-hoc manner in their groups, this arose as a consequence of the need to generate data within the limits of both time and individual circumstances – convenience, rather than any pre-planned triangulation strategy.

That is, although there were a number of sources of data available, they were all subsumed within the theory, in which it is stated that role perception and power relationships affected communication within the context of resource allocation, and that this in turn affected the process by which individuals are transferred across the primary/secondary health care interface. It would be more accurate to suggest that triangulation was attained by multiple interpretations of a single theory (within method triangulation) rather than by the application of multiple theories (across method triangulation).

2.4 Summary.

Ashworth (1997a and b) states that it is important to be aware of the suppositions regarding theory generation through data collection and analysis. Triangulation is a method by which the researcher can seek out information that serves to contradict or refute early expectations. This represents a failure of what Kirk and Miller (1986) refer to as "synchronic reliability". Kirk and Miller define synchronic reliability as the similarity of observations within the same period of time. They state that this type of reliability is most useful when it fails because it forces the researcher to generate new theories that can encompass the deviant case. Triangulation was, therefore, achieved by multiple data sources, interviews carried out among different occupational groups regarding the phenomenon of discharge planning, scrutiny by other members of the research team and by participants, and use of differing yet complementary methods and methodologies that transgressed the rigid paradigm divide. The types of triangulation

used in the study are given in Table: 2.1 (below).

Table: 2.1 Types of triangulation used in this study.

Type of triangulation.	**Approach.**	Purpose.
Method	Observation of nurse-patient interaction. Use of semi-structured interviews	To assess the quality and type of information given to service users. Identification of significant variables affecting discharge planning To examine perceptions of staff members regarding importance of variables. To assess role perceptions.
Data.	Time Space.	Wide understanding of the phenomenon over time and from different perspectives. Identification of contextual factors.
Investigator.	Researcher and director of studies	Combination of methodological and theoretical expertise.
Unit of analysis.	Individuals nurse/professional/ patient interaction, wards, documents significant incidents.	Complete understanding of the discharge planning process, its social context and implications.
Theory	Development and application of findings.	Understanding of the discharge planning process. Identification of significant variables.

2.5 Sampling and sample size within the study.

An examination of the sample sizes and characteristics is now in order. This is also related to triangulation in that the structure of the sample may, in itself, be an aid to the collection of relevant data. The gathering of data from different occupational groups ensured that the various perspectives of participants as members of a group were considered and allowed to inform the study. As Sandelowski (1995) points out, there is a common misconception that, when undertaking qualitative research, sample size is

relatively unimportant. The point is also made that sample size in qualitative research can only be considered in terms of the overall aim of the study and the phenomenon being studied. That is, there are no generalisable rules governing sample sizes. In this study there was a balance to be struck between the need to gather sufficient data to explore all the variations of the complex phenomenon of the discharge planning process fully, and the need to restrict the data in order that the narratives of the participants are apparent. It was, therefore, decided in conjunction with the researcher's supervisory team that forty interviews would be sufficient to enable sufficient depth to be reached in the interpretation of the phenomenon being studied. This, however, proved to be an overestimation because data saturation was achieved quickly during all phases of the study in that the same themes were found to recur within the data provided by the participants. The number of interviews was, therefore, reduced.

Regarding the status of the interview participants, decisions were predominantly governed by considerations of convenience and accessibility (for both the participants and the researcher). Snowball sampling was used on occasions. Bowling (1997) and Polit and Hungler (1991) define snowballing as recruitment of other participants by an initial small group of participants. Throughout the study staff members suggested names of others who might like to participate in the study. Since the wards had already been chosen (see the introduction to the discussion of findings) it was hoped that as many staff as possible would participate in the interviews. This included all grades of nursing staff, social workers and medical staff. Time and workload, however, prevented all but two of the medical staff taking part and the two that did had limited time to be interviewed. Interviews with social workers and specialist nurses were unproblematic.

Nursing staff, however, particularly at Trust B, were difficult to interview. Each day the researcher arrived on the ward for his designated period of duty and each day nurses said that they were willing to be interviewed but then ran out of time, or were busy. A number did not wish to be interviewed. Thus, other methods of sampling than convenience proved unworkable despite the fact that two separate stratagems were used to elicit nurses` participation (see the ethical dilemmas section below).

2.6 Reliability and validity within the study: producing trustworthy findings.

Kvale (1995) examines the debate concerning reliability and validity in the context of post-modern research endeavours. He discusses the two opposing outlooks concerning the importance of these concepts, they are that validity and reliability are the "holy trinity" of positivist science or that they are to be ignored by post-modernist researchers as artefacts from the positivist monolith. In some ways the debate parallels the debate concerning the principle paradigms used in research (see above). In attempting to construct a scheme that accurately reflects truths within the process of discharge planning and staff perceptions of it within the two Trusts studied, validity of this construct is crucial. Within the construct validation criterion, therefore, there are two others. Kvale (1995, p.23) notes that there is also a pragmatic criterion of truth in which the truth of a knowledge statement is related to its practical consequences. This is perhaps the easiest type of validity to assess since it can be answered simply by asking "is this how the discharge planning process works in this area?" The validity of the overall construct is, however, more difficult to assess. This involves the incremental process of feedback from all participants involved and is an attempt to find the manner of relations between their perceptions and the pragmatic manifestations. It represents an attempt to find the degree of coherence in statements made by respondents, not the degree of logical coherence within statements, the coherence theory of truth, but the coherence between the statement and the actuality, between the saying or perceiving and the doing.

Kvale (1995) defines validity as "quality of craftsmanship". Craftsmanship implies that, in terms of qualitative research checks for validity, assuring validity is a continuous process and involves the researcher in an intimate relation with the participants and the findings. Validity commences with the framing of the research questions and ends with reporting which yields trustworthy and credible results. Bearing this in mind, strategies used in this study to maximise validity were:

- Thematizing (Kvale 1995), which ensured the soundness of the theoretical presuppositions, so that the progression from theory to the specific research questions to be investigated in the study was logical and explicit. The compilation of a literature review was used to generate specific theoretical information relating to the research.

• Interviewing (Kvale 1995), which involved ensuring that the reports of the participants were both trustworthy and that they encompassed all the relevant areas of the phenomenon being investigated. The trustworthiness of the reports was ensured by returning both the full transcripts and analysed transcripts to the participants. They were then invited to comment regarding the findings and to add any further comments that they felt were appropriate or to suggest amendments or clarifications. Data derived from observation and documents were also checked against the transcripts and any anomalies between the professed or perceived reality and the pragmatic reality were investigated further. Koch (1994, p.977) advises use of this method to establish what she calls credibility.

• Verifying (Kvale 1995) which involved reflexive judgements concerning the types of validation were relevant in the study. This involved theorising about triangulation and developing a strategy by means of which such triangulation could be put in to practice.

Koch (1994) also mentions other stratagems, which can serve to enhance validity including credibility, transferability and dependability (the last of these is in section 3.31). Credibility is enhanced when the researcher becomes reflexively aware of his or her role in the study. In this context the use of a field journal was invaluable in providing notes for reflection. Koch invokes the notion of prejudice (p.977), which is particularly helpful to the nurse researcher who may be in danger of taking much of what is heard and seen for granted. According to the authors cited by Koch, the term prejudice is far from pejorative. It represents those assumptions and value judgements that all researchers bring with them into the field setting and is composed of our experiences and self-history over time. The field journal was invaluable in generating material for reflection regarding these assumptions and challenging them thereby arriving at deeper insight and more complete interpretations of key events.

Of transferability (or "fittingness") Sandelowski (1986) reports that this involves the ability of findings to apply to contexts outside the original. She notes that:

> "...a study meets the criterion of fittingness when...its audience views its findings as meaningful and applicable in terms of their own experiences" (Sandelowski 1986).

Strauss and Corbin (1998) suggest that "the real merit of a substantive theory lies in its ability to speak specifically for the populations from which it was derived and to apply back to them".

By the combination of the above triangulation methods and methods of verification a study was produced which reflected the manner in which the two organisations operated and the perceptions of the staff involved. This allowed a substantive theory to be developed which accurately synthesised those same findings and allowed recommendations to be made for future practice in key areas.

Since part of the role of the researcher is to elucidate his or her role in the data generation process and the effects of the researcher in the field environment, matters concerning possible ethical dilemmas form an important area of the research strategy. Three of these dilemmas faced by the researcher during the course of the study are discussed in the following section.

2.7 Ethical dilemmas.

Ethical clearance was obtained for all phases of this study. Attendance was mandatory at one of the LREC meetings, at the other the information concerning the study and the authorisation by the LREC was transmitted by post. In both Trusts, ongoing support and monitoring was also provided by the nurse managers. Despite this, however, there were still ethical dilemmas to be resolved. For a more detailed discussion of some of the ethical dilemmas encountered during the course of the data collection phase, including the use of medical notes, see section (d) "The use of Documentary Evidence" (below). One of these instances related to the development of a rapport between the researcher and participants in the field setting. The other was related to similar information that was divulged during the course of two interviews. This information, although peripheral to the phenomena being explored, concerned perceived lapses in the care of patients.

In the case of the development of a rapport between members of an occupational group (in this case nurses) and myself this meant that, on occasions, I was a total insider. In terms of the concept of familiarity discussed above in "The Role of the Researcher" this

proved a double-edged sword. Familiarity meant that on occasions information was volunteered more readily but also that expectations by other staff concerning the number of nursing tasks carried out could seriously reduce the amount and quality of data collected. This familiarity, however, placed me in the invidious position of encountering jokes which some of the nurses made, some of which were at the expense of patients. This tension was evident almost as soon as the data collection process began in the first phase of the study. An extract from the practice diary indicates the nature of the dilemma and my feelings at the time.

> *I already find myself being rather more loyal to nurses then I would perhaps like. I find myself agreeing with them and taking their viewpoints. I don't think that identifying with a given population to this degree may be such a bad thing. Maybe one needs to be like a chameleon, identifying with each group as it is encountered but never identifying with one group only. Maybe this will enrich the data. It certainly seems to be the case that if you identify with nurses they are more likely to provide you with data as they perceive you not to be a threat. Identification acts sometimes as a kind of non-verbal prompt causing more to be divulged. Nonetheless, I do feel that I should remain aloof and guard against particularity but this is easier said than done. It becomes both very easy and very reassuring to identify with the in-crowd, laughing at their jokes and feeling part of the gang. It feels like you are cushioned and wrapped up, part of the "herd mentality". It is very, very difficult to be independent of thought and action to the required degree and to navigate the minefield of relationships.*

The doubt about the relationship to nurses in the light of sometimes-humorous remarks concerning patients never really dissipated. Had I attempted to prevent such remarks or registered displeasure in any other way, my position would possibly have become that of the complete outsider that would have prejudiced the collection of data. The fact of the change in position on the continuum is itself quite revealing. It illustrates the nature of relationships that prevail within the nursing profession. These relationships seem to be based on the tacit understanding that members of a group will stick together and not question the authority and legitimacy of the group. I never overcame this dilemma and did not attempt to jeopardise the relationships that were developed. The literature suggests that although it is common practice to joke in this manner, this serves as a release valve for the frustrations of nurses and possibly other occupational groups, the tacit assumption being that it should be overlooked. Since I did not witness any instances of this having a detrimental influence on patient care this was the stance taken.

There are two important points, however, which may be used to question the validity of such an approach. Firstly, it would be difficult to determine how patient care would be adversely affected by such an attitude displayed by nursing staff. How would one measure such a decrease in standards and if it could be measured, could one automatically assume that it arose as a direct consequence of that attitude which manifested itself in sometimes disparaging comments about patients?

Some authors (Sines 1994; Reynolds and Scott 2000) suggest that the exercise of empathy is not as prominent as one would expect in the caring professions. This is not to suggest that all nurses engage in at best unfunny or at worst disparaging remarks about people in their care nor that humour has no place in often stressful and emotional situations. What is, however, being suggested is that certain sorts of humour may, in certain individuals, over time, cause a lessening of respect for patients or betray an already low level of respect. This sort of humour also typically displays itself behind closed doors during nurse handover and the fact that such remarks are made behind the patients` backs is worrying, especially since this may reinforce the them-us distinction. The question is, therefore, whether this lack of empathy is a symptom or a cause of the attitude that manifests itself in black humour?

Once again this is revealing since it goes some way to answering the question about how nurses feel about patients that they consider to be undeserving or unpopular. During this study, incidents were noted of nurses and doctors categorising patients as being undeserving in some way. It may have been the inappropriateness of their admission, or their unreasonable demands for aftercare in the pre-discharge period as perceived by nursing and medical staff. Since such judgements did not, as far as I was aware, result in any form of maltreatment, I elected to wait and see what the findings from analysis revealed since this would allow dissemination of more concrete findings to a wider and possibly more influential audience. As a nurse, I freely admit to having used just the same type of humour in this same environment, and it was interesting how little I realised that its use is commonplace. As a researcher in this environment the change in individual perspective that was experienced meant that such humour was at times funny but on other occasions it was disturbing.

The second incident concerned a particular aspect of management strategy at one of the

Trusts. The following is an extract from an interview carried out with a staff nurse in answer to the questions concerning communication between management and staff involved in the direct provision of care.

> *"The trolley bay. Basically when patients come in to A&E, when they've got no beds to be admitted to, they're put in the trolley bay. But we've identified a problem because some patients can spend up to two days in there... We've had a couple of patients admitted to the ward who've come up, who've had no documentation done right and no care as such that they would expect to receive on the ward. We had a lady admitted who hadn't had a treatment sheet for two days and when she was admitted up, was hypothermic, hypotensive right. She was...basically she died four hours later.*
>
> *When we took the issue up with A&E about it they said to us that the trolley bay has got nothing to do with A&E. So what I'm saying is that worries me because from an organisational point of view, they organised that trolley bay but not...th...they hadn't looked at it in terms of erm...actually providing any care while the patients are in there.*
>
> *The managers have said well we can't have them all in the corridors can we? We'll stick `em in the trolley bay which is almost like a small ward. So the relatives are under the impression that they're in there, they're being looked after, they're being cared for, they're being treated, but they're not. Now this only was only really highlighted a few days ago to us and we went down to have a word with* [name] *and ...managers didn't seem to be able to grasp what we were saying. That if they'd have been admitted to our ward and left for two days, no documentation done, no treatment sheet, nothing, we'd be shot. But because they're in a trolley bay it's a no mans land and the rules don't apply down there".*

Clearly, leaving aside the question of responsibility, this was (if correct) a very serious breach in standards of patient care. The veracity of this story was at least partially confirmed when a ward manager on the same ward mentioned the same incident as giving cause for concern. Another staff nurse who worked some extra shifts in the "trolley bay" voiced concern over the standards of treatment that patients received, as did a HCA (both from different specialities).

The need to bring this situation to someone's attention or to ascertain whether this was already known about and being rectified was, therefore, obvious. The dilemma centered on whether the research programme would be compromised by any attempt to publicise this problem. Koch (1994) faced an identical problem and waited until completion of

the research programme before making her findings known. She also carried out the care herself on one occasion. The potential implications of disclosures made were such, however, that in this instance I had little choice but to investigate and obtain evidence before proceeding irrespective of the effect that this may have had on the programme of research. I discussed with the staff members involved whether they would have any qualms about these concerns being raised with a senior member of staff and, although this situation was already known to some managers (see interview segment above), the nurses consented. I assured them that their confidentiality would be maintained.

Attempts to make appointments with nurse managers failed, the reason given was that they had no time. One person interviewed, however, acknowledged the difficulties faced by management and staff in resolving the problem given the extremely high demand on the service. This situation, in fairness, is not only extant within the Trusts studied or even in the region. It would appear to be a countrywide phenomenon (see chapter two). The participant did point out that the Trust knew about this and that steps had been and were being taken in an attempt to rectify the situation. The appointment of a co-ordinator in the A&E department and the opening of a Medical Assessment Unit (MAU) are attempts to both relieve the pressure on A&E and ensure that acute beds are more efficiently used.

On subsequent visits to the ward, nurses who initially raised the issue claimed that the situation was improving although some operational difficulties regarding communication between the wards and the A&E department remained.

I therefore felt that although the situation needs to be monitored (and managers have put in place such a monitoring procedure) this was as far as it was possible to resolve this particular dilemma. The object of raising this with managers was to make the views of nurses known to the relevant persons in order that patient care could be improved. Managers are either aware of the situation now, or were aware of it previously and, according to the nurses, the situation is improving. The objectives, therefore, have been met. This is all that can reasonably be expected. As far as it was possible to tell (based upon subsequent contact and responses after these events) the research programme was not compromised. Indeed, those nurses who voiced their concerns did so in order that this area of care could be improved and were not unduly worried about loss of

confidentiality since this issue had been raised before.

The second ethical dilemma concerned the recruitment of potential participants for interview. At Trust A this was not a problem since enough of those who where approached consented to be interviewed. At Trust B, however, even though the same tactics were initially employed, the number agreeing to be interviewed was poor. It seemed that although I was welcomed in most settings the need to engage in the nursing routine of the ward came to predominate. As a consequence of this, although nurses agreed to be interviewed, when the time came for the interview few remained willing. It was felt that some method of obtaining access needed to be devised which would stress the need for interviews in return for agreeing to work on the wards. Ward managers were approached and the situation was explained to them. Although they were happy to be interviewed themselves (two interviews resulted from this) they pointed out that it was impossible to force nurses to give interviews. The lack of time that nurses had was also a factor since, in many cases, an interview would have meant nurses staying longer at the end of a shift which, understandably, few were willing to do. This dilemma was not resolved. All I could do was to ask repeatedly whether certain nurses were willing to be interviewed but this yielded disappointing results.

2.8 The insider-outsider continuum and access to the field setting.

Although the process of gaining access to the field setting proved to be both complicated and protracted (see section concerning ethical clearance in Appendix 1), once permission was given to commence data collection, the process by means of which field relationships were initiated, sustained, nurtured and ended proved to be equally as complex, as identified in the four stages on an insider-outsider continuum. They are complete observer, participant as observer (in which the researcher is more participant than observer), observer as participant (in which the reverse of the above applies), or complete participant. Participation and observation are normally assumed to be contradictory and conflicting – the more one participates, the less one can observe. From experience, however, such an assumption may be misplaced, particularly when grounding the study in a methodology that dictates that there should be an intimate relationship between researcher and co-researcher. It is subjective participation in the study setting that gives the researcher almost direct access to the thoughts and feelings

of the people around him, thereby reducing the chances of inaccurate observation. The threat to objectivity implied by the term "going native", if it exists at all, can be minimised by the use of those methods of triangulation discussed above.

Gaining access to the field setting became an important part of the study, though there is a danger of taking this step of the research for granted. There is far more to this than simply gaining ethical clearance and turning up at a particular ward or practice. If gaining access is taken literally, this will lead to the collection of data that is either incomplete or misleading. Gaining access involves not just entry in to the physical environment but also to the culture to be studied and establishing the highest possible level of rapport with potential participants.

Initially the research was conducted on wards from 07:30 hrs to approximately 15:00 hrs (early shift) or from 13:45 hrs until 21:00 hrs (late shift). Night shifts were even considered as a source of data but this necessitated joining the "nurse bank", which would have consumed considerable time for relatively little gain. It was found, however, that during the early morning the wards were very busy, it was impossible to obtain interviews because of the pressure on the nursing and medical staff to complete certain important tasks during this early period. The availability of medical notes was also at a premium since this was the time, following ward rounds, when doctors, nurses, discharge planners and social workers required those same notes in order to update them. Also, once it was discovered that routine participation in ward rounds was not yielding data of the required quality or quantity, it was decided to attend the wards from 09:00 hrs with no set completion time. This allowed more flexibility and greater access to the desired materials. This proved to be an error since the ward staff did not relate to me in the same manner. It was, therefore, important to clarify the nature of my relationship to participants. The collection of higher quality data and true entry in to the culture to be studied seemed to occur if the following conditions were met:

- The ward staff already knew me as a nurse.
- I was included in off-duty rosters for a given period of time, and finally;
- I allowed two acclimatisation days for each ward visited in order that staff would familiarise themselves with me as a nurse rather than a researcher.

This last point is also important in that nursing and medical staff present on the wards seemed to relate to me in a more positive manner if I was seen to participate in nursing care and to "get his hands dirty". It was decided, therefore, that subsequent visits to wards would begin with the sister or ward manager placing me on the shift rota, and that two days would be allowed to lapse before any effort was made at collection of data. Although this resulted in a loss of flexibility in which I could move between wards in response to critical incidents and the dictates of the study, and although this also meant that the question of balance in participant research between being used as another nurse and the collection of data needed clarification, this adjustment in strategy resulted in the collection of less superficial, more honest data from the participants. In terms of the insider outsider continuum then, the greatest rapport existed when all of the above conditions were satisfied. It was noticed for example that on several wards I was well known to the staff and this optimised the level of co-operation. Although this did not pertain to all wards in all hospitals, it was still possible, given the right approach and a certain degree of patience, to elicit good quality information from participants when only two of the above conditions were met.

2.9 Methods of data collection.

These fell into one of seven categories. These were:

a) Participation in ward rounds.

b) Attendance at multidisciplinary team meetings.

c) Observation and analysis of critical incidents in the ward environments.

d) Documentary evidence.

e) Semi-structured interviews.

The same methods were used throughout Phase I and Phase II of the study.

(a) Participation in ward rounds.

Participation in ward rounds did not yield data of sufficient quantity or quality to justify its continued inclusion as a formalised method of data collection in either Trust. Ward rounds did serve to provide confirmatory instances of poor discharge planning or communication and remained, therefore, a source of observational data used for triangulation. Initially it was decided to attend ward rounds in order to

observe the approaches of staff at the different Trusts. There was, however, little difference in the dynamic of the ward rounds between each Trust. Once again the medical staff tended to concentrate predominantly on the medical or surgical condition of patients. Within the surgical directorate this included such markers as bowel function, whether the patient was tolerating diet and fluids and the state of the surgical wound. There was limited interaction with patients and once it was decided that the patient was ready to go home the doctor would state a time of discharge and also whether any follow up in the outpatients department was necessary. Other arrangements were left to the nurse. Ward rounds as a primary source of data generation were, therefore, discontinued shortly after the commencement of Phase II. In some instances, however, ward rounds did provide critical incidents, which are discussed in the relevant part of the text.

b) Attendance at multidisciplinary team meetings (MDTMs).

Attendance at multidisciplinary team meetings proved to be a moderately useful method of data generation. MDTMs were not held on the surgical wards within both Trusts. If a protracted problem arose with the circumstances of a particular patient then a case conference was organised by members of the MDT. The staff on the surgical wards seemed to rely on formal and informal referral methods in order to ensure communication between the plethora of specialist nurses involved in the planning and delivery of care. Those MDTMs that were attended took place solely within the medical setting. In both Trusts, attendance varied. Discharge Liaison Nurses were always well represented as were occupational therapists and nurses. Consultant and social worker attendance varied. MDTMs did highlight patients who required complex assessments and also provided a source for critical incidents. These will be discussed below in the relevant parts of the text.

Table:2.2. Wards and times of Multidisciplinary Team Meetings in Trust A.

Ward.	Time of meeting.
A1	Held intermittently. (2)
A2	Wednesday at 10:30 am. (1)
A3	Not held. (0)
A4	Case conference as required. (0)
A5	Non currently in progress. (0)
A6	Tuesday pm. (1)
A7	Tuesday at 12:00pm. (3)
A8	Tuesday at 10:30am. (3)
A9	Tuesday at 11:00am. (6)

Figures in brackets indicate the number of meetings attended. It was impossible to attend some of the meetings because ward rounds with the bed management team also took place on Tuesday mornings and these were attended on six occasions. This, however, clashed with the times of the multidisciplinary meetings. The bed management ward rounds provided the same information as the multidisciplinary team meetings and also a "snapshot" of bed use within the hospital was obtained. The multidisciplinary team meetings allowed the researcher to examine relationships between members of the team but this was evident in the ward environment also. It was decided, therefore, that attending the bed management ward rounds would provide data of better quality.

Of the information within the table, surgical and orthopaedic wards fared least well in organising multidisciplinary meetings. There did not appear to be any set time at which multidisciplinary meetings were held. Indeed they were held intermittently or not at all on all the surgical and orthopaedic wards. Even ward A2 (surgery) could not guarantee that a meeting would be held despite attempts to ensure this. The paediatric ward did not have a set meeting but relied on case conferences to discuss individual children as required. The medical, elderly care and rehabilitation wards included in the study all arranged meetings and all meetings occurred. All staff approached thought that such meetings provided an opportunity to engage in that level of communication and reinforcement necessary to ensure good discharge planning and yet certain specialities found it difficult to ensure that circumstances were suitable for such meetings to occur.

The key mediators that determine whether or not a meeting occurs are staffing levels and workload. Since staffing levels throughout the Trust are uniform, this

leads to the supposition that it is the need to prepare patients for theatre which militates against attending meetings. Indeed, one orthopaedic nurse claimed that it was difficult to ensure that doctors and nurses were free to attend these meetings because of workload. Clearly some thought needs to be given to this as meetings of this sort do aid the transmission of discharge communication.

c) The Use of critical incidents.

The use of critical incidents as a method of collecting information presupposes a definition of critical incident technique that seems different to that employed by academics. Bowling (1997) defines critical incident technique as a method of eliciting key incidents from participants at interview in order to discover how they felt about the event in question and how they would react to future events of the same type. Polit and Hungler (1991) define the technique as a method to obtain data from the in depth analysis of incidents. In this study, however, critical incidents were generated from a variety of sources, namely, medical notes, interview transcripts and observation. Critical incidents in this study may be thought of as any incident that promotes reflexive understanding of the phenomenon or culture being observed on the part of the researcher. The use of critical incidents in what may be thought of as the broader sense (i.e. not solely derived from interviews) served two distinct purposes. It served as a method of data triangulation in which the validity of the assertions and perceptions of various participants could be tested with recourse to specific events in order to seek out areas of conflict between the professed and the actual practice. This is what Kirk and Miller (1986) call "anti-coherence".

A closely related purpose of the use of this brand of critical incident technique is that the data gathered by this method initially provided a broad overview of the discharge planning system and, furthermore, where problems occur within the discharge planning process. It is at this point that the sometimes intimate relationship between the participant and researcher becomes obvious. The critical incident technique contains the assumption that examination of a specific incident of practice by the co-participants leads to insights that will positively influence practice. Taking a more longitudinal view, however, although initially the examination of critical incidents obtained through documentary sources allowed the researcher insight, the analysis of the data and the

dissemination of findings among the participants meant that the potential to improve practice was extant. This can best be explained by reference to figure: 2.1 below. In the use of critical documentary incidents, it is the researcher who is engaged in critical reflexivity and critical analysis. Following analysis of the data and dissemination of the findings, however, it is the participants who engage in critical action. This critical action may, in turn, promote further reflexivity and analysis. Thus, the researcher is engaged in highlighting the relationships between problems or the constituent variables of a problem, which are then given to the participants in order to validate the researcher's interpretation.

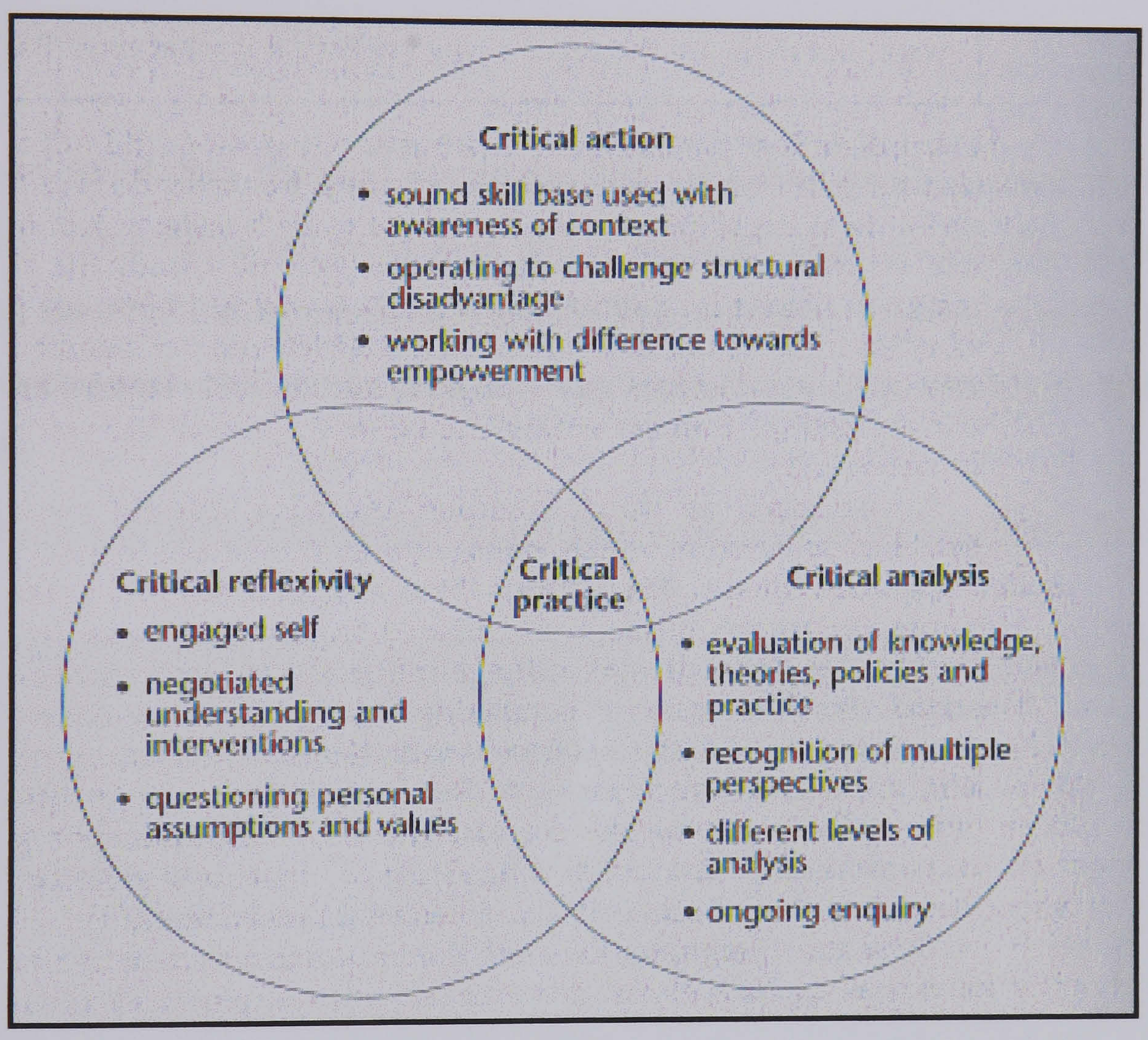


Figure: 2.1 The Elements of Critical Practice as a representation of the relationship between co-researchers. (After Brechin, Brown and Eby 2000,

This is related to both the interviewing techniques used within the study and the means whereby closure was obtained in the field setting at the end of the differing phases of data collection and will, therefore, be discussed in those sections as well.

d) The use of documentary evidence.

Documentary evidence gathered and analysed during the study consisted of the following:

- Policies concerning discharge planning bed management, admission and referral mechanisms.
- Memos from various departments.
- Data from admission books.
- Information from patient notes.

A list of documents analysed during the data collection phases is given in table 3.4 (below). This list is not exhaustive and is intended solely to demonstrate the wide ranging nature of the documentation and the large number of sources accessed. In some cases documents could not be cited as it was impossible to make them sufficiently non-specific.

Table: 2.3. List of documents utilised during the data collection phase in Trust A and Trust B.

Document Title.	Trust.
Memorandum to OT Department and copy of stroke care pathway	B
Joint agency for hospital discharge handbook.	B
Policy for the management of emergency admissions	B
Policy on the discharge of patients from hospital.	B
Bed management policy and procedure.	B
Bed management policy for [name].	B
Medical Admissions Ward operational guidelines.	B
The [name] Community Care Charter	A
Welcome to [name] Children's Unit.	A
Employee Guide to key Trust Policies	B
The NHS Plan: a summary.	-
[Name] Children's Unit: Service profile.	A
Going Home.	A
Macmillan Nursing Service	A
Discharge Planning Service	A
[Name] Medical Centre Pre-admission Assessment Clinic Information Pack	A
District Nursing in [Name]: Getting the best from our service	A
Discussion Paper on a model of a planned discharge system.	A
District Nursing: how to contact the service	A
Admission registers	A and B
Discharge monitoring meeting (22.9.99).	A
Changes Within the [name} Hospital Social Work Team	A

Access criteria/referral procedures for hospital social work teams	A
Nursing assessment protocol	A
Operational Policy – Discharge Lounge.	A
Admission and bed management policy	A
Hospital Discharge Policy	A
Access Criteria for Community Care and Continuing Health Care	A and B
Criteria for step-down to [name].	A
Discharge Planning Service Ward Resource/ Service Information Pack	A
What happens now? Information for patients concerning hospital discharge and continuing health care arrangements.	A
Commenting on our service	B
The [name] Hospice.	-
Carehome Selection: patient information leaflets.	-
[Name] and [Name] Collaboration Project: Bringing services Closer together	A
Video on hospital discharge arrangements.	B
Cognitive Performance Scale	B
Inter-agency Monitoring Group: Discharge Concerns Monitoring Report.	B
Choosing Nursing or residential Placements Using Carehome Selection.	B
Sitrep Summaries	A and B
Occupational Therapy Department: Information pack	B
Clarification of terminology used in the complex assessment process	B
Criteria for admission to the Stroke Unit.	B
Assessment checklist for rehabilitation patients.	B
Memorandum re difficulties in medical review of outliers.	B
Delayed Discharges in Birmingham.	All
Joint Hospital Discharge Policy Training Resource Pack.	A
Joint Hospital Discharge Policy Workshop Evaluation form.	B
List of Voluntary Homes.	A and B
Local GP list.	A and B

The use of documentary data is potentially problematic and care is needed regarding the exact nature of the information which it is hoped to gain, the completeness of the information, possible biases, and consistency in relation to other sources of data (McEvoy 1999). The most immediate problems occur when one attempts to assess the exact status of patient notes. Although patient notes provide a ready source of accessible material, the ethical status of their use in this manner must be resolved. McEvoy (1999) outlines two commonly taken positions in relation to their use for research purposes.

The first position stipulates that the right to patient privacy should be paramount and

that, therefore, patients` notes should only be used once the principle of informed consent has been safeguarded. The second position is that the principle of the greater good should be recognised and it is, therefore, legitimate to use patient material in pursuance of this. It is important to note, however, that the decision to adopt the latter position does not minimise the need for sensitivity or the need to ensure that privacy is maintained. Neither does it legitimate the acceptance of the principle that is occasionally advanced that there is a tacit agreement between clients and health care professional that the notes may be viewed by other health care professionals. This may be acceptable within the narrower confines of immediate therapeutic benefit to the patient concerned, but this could not be said to include non-therapeutic research of this nature.

Approval to undertake the research was given by the Local Research Ethics Committees (LRECs) in the second sense that it contributed to knowledge of current practices that may benefit future patients. Approval was conditional, however, upon the provision of three assurances - that the researcher would seek permission where appropriate from the health care professional involved in the care of a particular patient, that all information would be held securely in order to prevent unauthorised access and/or disclosure, and to ensure that the anonymity of patients was maintained. Approval by an LREC is recognised as an exception to the rule of strict confidentiality by the General Medical Council (Mason and McCall-Smith (1994) and the NHS Executive's draft code on confidentiality (Brazier 1992, p.431). As well as these safeguards the researcher also reminded the LREC panel that he was bound by the strictures of the UKCC Code of Professional Conduct (1992) regarding confidentiality in respect of patient information. The relevant clause states that the health practitioner should

> "Protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required by order of a court or where you can justify disclosure in the wider public interest" (UKCC, 1992).

Since the aim of the research was to formulate recommendations, which would improve communication across the primary/secondary health care interface in respect of vulnerable persons` discharge from hospital, the disclosure of the information contained within these pages is justified in terms of the wider public interest by the fact that it may

benefit other patients in the future.

The documents used in the study were used for the following reasons. The use of policies represents the articulation of an ideal state of affairs deemed to be most effective in the realisation of organisational goals. These documents acted as templates by comparison with which real standards of practice were measured. These documents therefore served to illuminate poor areas of practice and the reasons for them by comparing them with the clinical and environmental realities that they are supposed to influence. As such, although they were templates, they were themselves influenced by that reality. Analysis of content (Bowling 1997) reveals that the documents contain desires, goals, resources and levels of conflict.

Memos from various departments, although capable of being examined for content, are rather more specific since they arise as a consequence of a need to clarify desires and goals, to ameliorate potential conflict or to influence social operations within or between groups. Although only a small number of documents of this nature were used they were, nonetheless, enlightening since included in this category were documents dealing with complaints or clinical incidents.

The final category of documentation used in the study was ward-based documentation. In to this category were subsumed patient notes and information from sources such as admission books and details of medical outliers. The least problematic documents were the latter because although there was some subjective interpretation involved regarding the exact diagnosis and, therefore, speciality under which the patient was admitted enough information was still available to enable valid conclusions to be drawn from their analysis. Patient notes were used in order to obtain incidents relating to the relationship between the various disciplines and discharge planning. They were also in themselves interesting because an audit of the manner and depth to which notes were completed gave some idea of the effect of incomplete documentation on the discharge planning as a whole. In attempting to use these notes to ascertain relations between members of the multidisciplinary team, Silverman's (1993) exhortations to caution were borne in mind. It was immediately obvious that the medical notes of patients were a direct attempt on the part of staff to apportion blame in incidents of either conflict or uncertainty and that

notes were, therefore, an attempt to supplant one version of social reality with a more desirable one. Silverman notes that, given time, written documentation comes to supplant the reality that it was originally intended to represent. This source of potential bias was turned to advantage, however, since specific incidents could be examined and the various interpretations collated thus allowing the emergence of a more representative and, therefore, trustworthy narrative. The problem of long acquaintance with the nursing profession meant that it was important to question assumptions concerning all documentation and not simply take the veracity of the documents for granted.

Sources of documentary evidence within Trust A included a bed occupancy study, policies relating to discharge, use of the discharge lounge, bed management, record keeping and a Social Services Activity Summary. Also included are data from admissions registers at ward level and the data generated from examination of approximately 60 sets of case notes. The number of documentary sources of evidence available within both Trusts meant that this form of data collection assumed great importance. This was particularly true given the paucity of data collected from other sources, notably interviews Trust B). Documentary sources used in this study included admissions books at ward level, information from discharge liaison staff, a survey carried out into discharge planning, numerous policies, information from medical notes and documentation concerning complaints.

e) The use of interviews in qualitative research.

The use of the semi-structured or focused interview provided arguably the most important method of data generation used in the study. Ensuring trustworthiness of material gained from interviews demands well planned interview techniques and knowledge of how information can be tainted by poor interview technique. Analysis of transcripts also presents potential problems. Despite this, however, this was one of the more rewarding aspects of the study. Kvale (1996) proposes that the researcher should strive during interviews to promote objectivity in the form of freedom from bias, an intersubjective knowledge and to reflect the nature of the object. This can be achieved by means of agreement through rational discourse and reciprocal critique – what Kvale

calls communicative validation. Finally, Kvale (1996) lists the attributes of the competent interviewer. S/he should structure the interview by introducing a purpose, outlining the procedure and recapitulating at the end. S/he should also be clear, gentle, open and sensitive, yet critical at the same time in order that the true inter-view, an exchange of views between co-participants may occur. The interviews undertaken, the Trust, speciality, grade of participant and approximate duration of the interview are given in Table 2.4.

Table: 2.4. Interviews carried out within Trust: A by status, speciality duration and method of data collection.

Title & Grade.	Speciality.	Duration.	Method.
Nurse (E/F)	Surgical.	50 min.	Audio.
Nurse (E).	Surgical.	1hr, 40 min.	Audio.
Nurse(G)	Surgical.	1hr, 50 min.	Audio.
Nurse (F).	Surgical.	40 min.	Audio.
Nurse (E)	Surgical.	35 min.	Audio.
Discharge planning Sr	Hosp/comm.	1 day.	Written.
Social worker (x3)	Hosp/comm.	1 day.	Written.
Manager.	Paediatrics.	1 hr, 45 min.	Audio.
Manager.	Surgical.	1 hr.	Audio.
Nurse (F).	Surgical.	1 hr, 40 min.	Audio.
Nurse (G)	Surgical.	1 hr, 30 min.	Audio.
CNS.		2 hrs.	Audio.
Bed management team.		Weekly.	Written.
Waiting list manager.		25 min.	Written.
GP based community nurse.		Morning.	Written.

Interviews were carried out in hospital wards, GP surgeries and Social Services Departments. The interviews ranged from full interview sessions with minimal distractions, which lasted between fifteen minutes and one and a quarter hours to smaller, less structured interviews lasting fifteen to twenty minutes. This depended greatly on the time that the respective staff had available. Appointments were made whenever possible but this did not guarantee access and in some instances the interview was either prematurely shortened or immediately terminated due to pressure of work. The staff who participated worked in a variety of clinical settings, both hospital and community based. The grades and titles of staff who participated within Trust A are tabulated below. Also included are the duration of interview, speciality and the method used in data capture.

It is noticeable that there were no formal interviews with staff of the medical directorate.

This was because the staff had no wish to provide information in the formal setting but there are numerous instances where staff of these departments provided information and this is given in the chapter dealing with the findings from Trust: A. Though this may be considered a limitation of the study it became apparent that problems with throughput, although more acute in the medical setting, are not the province of that setting alone. Problems with the discharge planning process generally were also not confined to individual specialities. The title of the staff members or their speciality has not been given in full in order to protect anonymity. The situation in Trust: B (as has already been noted) was considerably worse. Few staff had the time or the wish to be interviewed in a formal manner and it became necessary to elicit information in short bursts when the nurses` time permitted.

Table: 2.5. Interviews carried out within Trust: B by status, duration and method of data collection.

Title & (Grade).	Speciality.	Duration.	Method.
Nurse (E).	Surgical.	60 min.	Audio.
Nurse (D).	Surgical.	40 min.	Audio.
OT.		1 day.	Written.
Discharge Liaison Nurse.		1 day.	Written.
Nurse (F).	Medical.	40 min.	Written.
Nurse (G)	Medical.	30 min.	Written.
Social worker.		1 day	Written.
CNS		25 min.	Written.
HO and SHO.	Surgical.	20 min.	Audio.

As can be seen, although representatives of the medical directorate were included in the study as well as two junior doctors, the interview times were relatively short and the majority were written rather than recorded. The status of the participant, their speciality, the duration of the interview and the method of information capture are given in Table: 2.5 (above).

As can be seen from table 2.5, the vast majority of staff were reluctant to have their comments tape- recorded, this necessitated the making and transcribing of notes after the event. This was not an ideal situation since many important contextual and linguistic cues are not present in the finished transcription and there was no guarantee that everything that was said was recorded. Although written transcripts of interviews represent an inferior method of attempting to interpret in an unbiased manner the reality of the participants, there was little choice since this was the only

method available in most cases.

2.10 The staff interview schedule.

The staff interview schedule consisted initially of 15 questions but was later lengthened to include an extra five questions which it was thought either needed to be included in an attempt to elicit specific information that had arisen during preliminary interviews, or provide clarification. All questions are given In Appendix: 2, as are the justifications for the use of each question and the information it was hoped would be volunteered when the question was asked. It was decided that forty interviews would be conducted among hospital and community based staff nurses, social workers, discharge planning sisters, Senior House Officers and House Officers nearing the end of their rotation. This interview schedule was used in all interviews of health care professionals in order that a means of comparison existed across the varying occupational groups. Each question had, therefore, to be sufficiently broad to apply to each member of the occupational groups sampled and also allow subjective narrative rather than constrained response to develop. These questions are, then, indicators of the types of subject that were examined during interview, further sub-questions followed depending on the direction of the interview which was, in the vast majority of cases, dictated by the participant.

It should be noted that medical staff were considerably more difficult to gain agreement to be interviewed than were others and they were of a shorter duration than other members of the multidisciplinary team who agreed to participate.

Interviews with all grades of staff were conducted within the healthcare facility in which the staff were employed, the time of the commencement and termination of the interview was noted, as was the name, ward and grade or designation of the person concerned. All participants where informed of the broad nature of the interview and of their right either to refuse to answer individual questions or to withdraw from the interview at any time.

Participants were also informed that the interviews would be transcribed and that all personal details would be deleted. Finally, the respondents were informed that they were free to see the copy of the transcribed interview and to make further suggestions

and have desired parts of the text altered if they so wished. Initially it was envisaged that, during the interviews, notes would be made as well as the audio recording. The purpose of this was to "flag" other possible areas for exploration that may have been mentioned by the participants. This would have served to gradually direct this and future interviews so that, over time, the interviews would become gradually more structured, as the dimensions of the phenomenon became known. In practice this was more difficult and note taking was soon abandoned. One of the problems with note taking was that it was difficult to give full attention to the participants and, as a consequence, the opportunity to reassure the respondent using verbal cues was lost. Also it was difficult to obtain the most from the interview encounter using interrogatory or confirmatory questions. This is related to the insider-outsider continuum since the taking of notes, and the consequences thereof, served to distance the researcher from the participant. The interview thus became less like an encounter between two nurses as note taking made the fact that research was being undertaken more explicit. It served to shift the focus of the encounter away from an interest in the participant and the encounter to the narrower and more selfish interest of the information being generated.

2.11 Analysing the data: the decision trail.

As part of the means by which research is rendered both intelligible to the participants, contextually sensitive and trustworthy, as well as credible, transferable, fitting and all the other myriad names which good research must apparently have, as part of the process of ensuring validity, Koch (1994) asserts that the process whereby the researcher arrived at the conclusions must be clearly visible (see also Sandelowski 1986; Koch and Harrington 1998). That is, in the case of documentary evidence and interview transcripts there must be a logical, valid and visible progression from the raw data to the conclusions drawn from that same data. Savage (2000) suggests that analysis contains description and interpretation; the former may stand on its own and may be thought of as pragmatic/thematic since it attempts to answer the question of what is happening. The next stage of the analysis is the interpretation or the synthetic/thematic element. In this study these two levels operated simultaneously during the data collection phase. It was necessary to know both what was going on and what this meant. It was, therefore important that a coding scheme was developed which was

flexible enough to encompass the pragmatic as well as the perceptual.

The following sections will indicate how the "raw" data was treated, how progression from unabridged interview transcripts to conceptual frameworks and emergent themes was accomplished. The process of content analysis was used to treat and analyse the data. This process is defined as "a procedure for measuring verbal or written communication in a systematic and objective fashion..." (Polit and Hungler 1991). Miles and Huberman (1994) define the deconstruction and coding process as the construction of categories so that data can be systematically analysed. This method of analysis allows multiple coding strategies (Strauss and Corbin 1998) and, therefore, allows multiple interpretations of possible social perspectives to be accommodated. It is, therefore, entirely consistent with the ethnomethodological enterprise in ensuring that no social perspective is overlooked.

2.12 Treatment of the data: reduction and analysis of the transcripts.

The treatment of the data occurred in seven stages as outlined by Kvale (1995). These were:

- Transcription of the audio or documentary interview notes.
- Removal of repetitions and exclamations and the numbering of the transcript lines.
- Breaking down the interview transcript into meaning segments.
- Labelling of segments with explanatory text boxes.
- Development of a coding scheme for each interview.
- Amalgamation of the coding schemes.
- Development of the conceptual explanatory framework.

Step: 1. Following the transcription of the recording the interview transcript was read a number of times to enable the researcher to retain a general idea of the interview, its context and associated memories and to increase the receptivity of the researcher to the broad themes emerging from the transcript. Other relevant information was recorded in the field journal. Included were details of where the interview took place, what the

atmosphere was like and how the researcher felt before, during and after the interviews.

Step: 2. Following this the analysis process began. The interview was examined and all remarks made by the interviewer were removed from the transcript. This was done in order to facilitate deconstruction, whereby all contexts are removed from a text in order to allow new interpretations to emerge. Layder (1997) discusses de-centring the subject in which he claims that the subject cannot be considered the only source of social meaning and social structure. Deconstruction allows the ideas contained within the text to be isolated and reconstructed at a later date. It was occasionally necessary to refer back to the original transcript because the meaning of a statement was lost. These occasions were, however, rare. Also removed from the text at this time were grammatical repetitions such as pauses. This was done carefully to ensure that the meaning and possible interpretation of the text was not compromised.

Step: 3. The text was then separated in to what Burnard (1994a) calls "meaning segments". This is the beginning of what Strauss and Corbin (1998) term "analysis of data through microscopic examination" and this open coding is the necessary precursor to concept generation and synthesis. It involves appraisal line-by-line since, in attempting to break up the context of the transcript, it is important that meaning is undisturbed, that certain links in the chain remain connected, otherwise interpretation will become difficult if not impossible. Having carried out these exercises the data was reduced and the following series of isolated statements remained.

Step: 4. Following this breakdown into meaning units each transcript was then printed and the meaning units isolated, their origin was indicated by the number of the interview placed after the text and the line numbers in the margin. Each segment was then examined closely for themes (Strauss and Corbin 1998; Birley and Moreland 1998). Since each set of data was coded more than once, the segments were initially examined for comments regarding structure and process, statements concerning the practical workings of the discharge planning process within this Trust. This enabled the researcher to gain a broad overview of how the system works (taken in conjunction with other sources to avoid incorrect interpretations). The data was also examined for perceptions of the staff member concerned. At this stage no categorisation was carried out, rather a restatement of

the segment's meaning was carried out. The interpretation and restatement was written on paper and stapled to the segment. This allowed sufficient space and flexibility to write down new interpretations should they arise.

The analytic tools used are outlined by Strauss and Corbin (1998, p.87-99), questioning the data, the analysis of a word, phrase or sentence and comparison of data. This was achieved through a process of coding. Both open and axial coding were used (Strauss and Corbin 1998). Open coding was undertaken initially in order that the basic categories of the future explanatory scheme could emerge. This was undertaken concurrently with, and closely allied to, the literature review. Since, at this stage of the research, research questions remained unformulated open coding allowed the intermeshing of direct experience with findings from the literature in order that the phenomenon could be more fully conceptualised in both its range and depth. Axial coding then occurred in which explanations for specific utterances were sought. At this point analysis became largely independent of the literature as emerging themes were analysed repeatedly in order that no possible interpretations were missed. Each interview was coded separately to aid the process of ideational saturation. Only then were the interview coding schemes amalgamated as the explanatory framework was honed. Thus, steps taken in both documentary analysis and interview analysis were identical in that data was analysed and categorised rigorously in order that the numerous latent meanings were captured and made transparent.

Step: 5. Having reduced the data and interpreted it using small notes and observations attached to the segment, the segments were then studied to examine whether or not any categories were immediately apparent (Strauss and Corbin 1998). Early concepts were delineated in this manner. This involved the grouping of the segments into sets in which the theme of the segments seemed to be indicating the same concept. All segments were included in the analysis.

Step: 6. These steps were carried out for each interview transcript. Thus, each transcript was reduced to a coding scheme like that above. Following this, the coding schemes were then amalgamated by examining the concepts from each and including them in this larger scheme. This proved useful since this method was sufficiently sensitive to allow the emergence of other concepts from other interviews and their subsequent

inclusion. Had a coding scheme been used in which concepts from the initial interviews had been used, there may have been the danger that other emerging concepts would have been distorted to fit into the already extant scheme. If more important categories were found they were included (for example issues concerning education or the role of the specialist nurse). Each category and sub-category is then discussed in detail. In order both that the various meaning segments are traceable to their point of origin and that the segments can be easily cited within the main body of the text, the following notation scheme was employed. Each segment has as the first letter the method by means of which it was captured, followed by the number of the interview transcript from which it came. The third letter denotes the Trust followed by the lines it occupied within the original transcript. Thus, citations will read, for example, I1A; (222-224). This obviates the need to keep repeating sections of interview transcripts throughout the text. Having discussed all theoretical and practical elements of this study, from paradigmatic assumptions and methodological issues, through instrumentation and the treatment and reduction of data into an explanatory framework, the final section in this chapter is concerned with the quitting of the field environment and the attempts made to obtain proper closure of this phase of the study.

2.13 Quitting the field environment.

Quitting the field environment and obtaining closure proved to be one of the most difficult components of the research process. Although one can readily empathise with staff regarding the need for closure, it is easy to neglect this part of the process once the data collection phase is complete but its importance should not be overlooked. To leave the relationship between researcher and participants or co-participants unfinished promotes feelings of resentment and confusion among participants that operate both on a personal and organisational level. Resentment stems from the fact that failure to achieve closure, failure to acknowledge that the end point of the research has been reached to the satisfaction of those persons involved may give the impression that the participant's contribution has been insufficiently valued by the researcher if it has been valued at all. It is important to remember that the participant's contribution to the research takes many forms; the time they have invested, the personal relationship which has in some cases been built up with the researcher, as well as the courage that it takes both to be interviewed and divulge information, the giving of which may be seen to

open up the possibility of sanctions or implicit threat if not handled in a sensitive manner by the researcher.

Confusion may arise at the level of the participant's relationship to the organisation. Many participants expressed a desire to know both how their unique contribution influenced the study and the findings of the study as a whole. This indicated the consensual, symbiotic nature of the research and suggests that ownership of the materials used and transmuted throughout the research process does not lie solely with the researcher. Indeed, if research is to have any base in, or influence upon clinical practice, this consensual nature should be acknowledged and research disseminated to the providers of information in that they can transform critical reflexivity and critical analysis in to critical action. In other words, a degree of enablement or empowerment of the participants is a crucial step in any form of research. As well as being common courtesy, this sharing and transforming of information is one of the chief benefits of obtaining satisfactory closure once the data collection phase of the study has ended (this is also discussed in that section above, concerning the use of critical incidents within the study). The other more personal aspect of closure ensures that the participant receives information and that their role in the data collection process is both acknowledged and verified as being useful.

Whilst this may seem self-evident and unproblematic from a theoretical point of view, ensuring that these requirements were met within this study posed certain practical dilemmas. Obtaining closure having collected data from a particular ward proved difficult. Because of the number of wards involved and the need to revisit wards on several occasions to follow up new leads and examine admission books, this meant that it was impossible to say with certainty that data collection had finished. It was, therefore, decided to try and maintain field relationships and postpone closure until the study was complete. This involved visiting the wards and talking with staff. At Trust: A this was less of a problem because the researcher is well known and could, therefore, visit the wards there less frequently and be reasonably secure in the knowledge that the relationships would not be damaged. At Trust:B, however, this assumption of the strength of field relationships could not be made and this necessitated more frequent visits. The postponement of closure until the study was complete enabled definite conclusions and recommendations to be given to those staff who requested them.

Accordingly, at the end of the study, each ward was visited with a card for all those staff on the wards, departments and GP practices with a message of thanks as well as a summary containing the main conclusions of the study. The conclusions were made as pertinent to the ward as possible. The researcher also stayed on the ward for a period of time so that all staff currently working could be seen (on the late and early shifts). In this way satisfactory closure was achieved.

Chapter Three: Findings from Phase I of the study.

3.1 Introduction.

The data presented here was collected at a 557 bed health care facility (Trust A). There is also a sister hospital which specialises in elderly care and rehabilitation, this facility has 119 beds. Data collection has also been carried out at one community based institution. The wards selected at Trust A and their specialisms are given in Table 3.1 (below). The names of all wards have been substituted by a code to ensure that anonymity is preserved. The letter denotes the Trust of which the individual ward forms a part, whilst the individual ward is denoted by the number.

Table: 3.1. Number of wards chosen in Trust A and their specialism.

Ward code.	Speciality.
A1.	Surgery.
A2.	Surgery.
A3.	Short stay surgery.
A4.	Paediatrics.
A5.	Orthopaedics.
A6.	Orthopaedics.
A7.	Elderly care.
A8.	Orthopaedic rehabilitation.
A9.	Medical.
A10.	Rehabilitation.
A11.	Elderly care.
A12.	Medical.

3.2 Findings.

The findings are presented under headings generated by the coding of interview segments, which were formulated through the use of the decision trail (Miles and Huberman 1994) in which relevant and recurring themes formed the basis for the coding process. Thus, although community services are not discussed in a specific section, they are discussed in the section dealing with fragmentation of service delivery since it became apparent that, within the acute care setting, this was where their impact was felt to be greatest. Summaries are not given in this chapter since each category is intended to be separate and detailed discussion of the findings will occur with reference to current literature in chapter six.

The first part of this section examines the population type of Trust A and the effect that this has on admission to hospital. That is, what type of person is admitted, how are they admitted and what consequences does this have upon conflict, communication and perceptions within the discharge planning process?

3.3 Population structure and its effects on admission.

The Ninth Annual Report of the Director of Public Health (1997) gives the mid-1996 population within the catchment area of Trust A as 292,196. By 2002 the population as a whole was expected to have declined by 0.08%. Whilst the numbers of people aged between 65 and 74 years of age were expected to decline by 6.56%, those aged between 75 and 84 years of age were expected to increase by

3.52% and those aged 85 and over to increase by 18.15%. According to the Annual Report of Social Services Activity (1999) "population estimates for 1998 record that 8.6% of the population resident [within the catchment area of Trust A] were aged between 65 and 74, 5.6% were aged 75 to 84 and 1.7% were aged 85 and over" (see table 3.2, below). In table 3.2 the final column represents the actual and percentage difference between the two figures. The other percentages displayed are the percentages of those age groups in the population for the specified year.

Table: 3.2. Projected population figures for projected age groups in the catchment area of Trust A based upon comparisons of Public Health and Social Services Data.

Age group.	**Public Health (%pop).**		**Social Services (%pop).**		Actual and (%) difference.	
	1996.		1998.			
65-74.	26,456	(9.0)	25,150	(8.6)	-1309	(-4.9)
75-84.	16,181	(5.5)	16,301	(5.6)	+120	(+0.73)
85+	4,782	(1.6)	5003	(1.7)	+221	(+4.4)
TOTAL	47,419	(16.2)	46,454	(15.9)	-956	(-2.03)
.						

Table 3.3 (below) gives the Department of Public Health's population estimates for the year 2002. By combining the two yearly changes given in table 3.2 and the predicted growth from 1996 to 2002, given in table 3.3, the data indicates that whilst the population aged between 65 and 74 has fallen and will continue to fall, other older age groups (in particular those aged over 85 years) will continue to rise.

Table 3.3. Predicted population in the catchment area of Trust A by 2002.

Age group.	Predicted population by 2002.	% difference.
65-74.	24,720	-6.56
75-84.	16,750	+3.52
85+.	5,650	+18.15
TOTALS	47,120	+0.63

The Standardised Death Rate (SDR) from coronary heart disease Trust A is higher in this area than in the West Midlands region as a whole and in England and Wales (in all age groups) as is the incidence of cerebro-vascular accident. The following section deals with admission to selected wards within Trust A. The purpose of this is to make explicit the tensions caused by a finite level of resources coupled with

excessive demand and the effect that this has on staff perceptions and methods of communication within the discharge planning process.

3.4 Modes of admission and bed use within Trust A.

Ward based staff perceive the correct utilisation of beds as the most pressing aspect of resource allocation since it impacts heavily upon their workload and the levels of stress they experience. The concept of correct bed use held by nursing staff (for example) is continually violated by outside pressures. Such outside pressures arise in part as a consequence of the population structure and the resources made available to meet the demands but they may be exacerbated because different disciplines have differing views concerning the correct utilisation of resources. This clash of differing views can cause conflict, especially if communication between disciplines is poor. This in turn affects group behaviour, which, finally, affects the implementation of arrangements for the discharging of patients.

Patients are commonly admitted to the secondary care facility of the Trust either electively or as a medical or surgical emergency. Emergency admissions arrive in the Accident and Emergency Department and a decision is taken whether to admit them or discharge them.

The picture is further complicated, however, by the fact that at certain times of the year the number of people who are admitted through Accident and Emergency means that the number of beds available is drastically reduced. The best known aspect of this phenomenon is winter bed pressure but according to staff such pressures can arise at any time of the year. In winter, for example, icy conditions bring an increase in the number of older people suffering falls resulting in fractured hips. Particularly hot conditions during the summer months result in an increase in admissions among people suffering from asthma and related respiratory diseases. Such times where peak capacity is exceeded by demand are, therefore, more accurately termed "weather pressures" since the phrase "winter pressures" only reveals part of the picture. Indeed, so much is bed capacity dependent on weather that many hospitals receive weather forecasts from the Meteorological Office.

This upsurge in the number of seasonal emergency admissions mean that there are not enough rehabilitation beds available and many older people find themselves on acute medical wards after the acute phase of their illness has passed. Because of this overspill elective orthopaedic and general surgical operations must be cancelled as those patients who are termed "outliers" reduce the capacity of the establishment to house elective patients. Table 3.4 (below) gives the number of elective surgical admissions cancelled in five months over a four year period. The timing of the cancellations is significant. The cancellations listed in the table concern those persons whose operation was cancelled on the day due to nil bed availability (operations can also be cancelled because of lack of theatre time or illness of the patient or consultant). The patient must then be given a new date for admission within one calendar month of the cancellation date otherwise the Trust will be in breach of Patient's Charter arrangements.

Table: 3.4. Number of elective surgical admissions cancelled because of bed shortage in the months of January to June over a four year period (From bed management data).

Month.	1996.	1997	1998	1999
January	62	23	4	6
February	70	0	11	3
March	40	9	2	14
April	6	2	1	0
May	5	3	1	6
June	4	2	2	0

Other patients who suffer cancellations twenty-four hours or longer before their operations are not affected by this. Between 1996 and 1998 (the exact date is unknown) the system of cancellation was changed. Trust A now operates a more proactive cancellation policy based on projected bed occupancy and now cancels patients a week before. Thus, although cancellations based on Charter standards are declining the real trend is uncertain. Figures for April, May, June and July 2000 indicate cancellations of 16, 19, 11 and zero patients respectively (on the day of surgery). It is, therefore, legitimate to assert that the number of elective patients cancelled is directly proportional to bed availability and that despite attempts to find beds significant numbers of patients are still cancelled on the day of their proposed surgery. Experienced staff endorsed this interpretation. It should be noted that the

Trust has undertaken a number of initiatives to try and ensure bed availability. Most notable is the process (currently being "rolled out") whereby patients suggest convenient dates for their surgery and their admission date is based upon these. Laudable as such initiatives are, however, they will only enjoy limited success as long as there is either severely limited or non-existent "slack" within the system.

Data obtained from admission books serves to highlight the seriousness of the problem. Tables 3.5 and 3.6 (below) detail admissions to a surgical ward in July, August and September 1999. The information for September is not tabulated since incomplete admission registers meant that length of stay could not be calculated in the majority of hospital episodes. The tables were used to provide the following information. The average age of admissions to surgical wards, the number of apparently inappropriate admissions to surgical wards (i.e. the number of medical or orthopaedic outliers) and the number of presenting conditions which may require complex assessments and planning prior to discharge. The tables also give some indication of the number of bed days lost to elective and emergency surgical patients because of occupation of beds by these same outliers.

Patients are assigned a probable speciality on the basis of the following information. The speciality or consultant they were admitted under (column two), their presenting complaint/diagnosis and their transfer to a more appropriate ward. Thus, those patients who were admitted under a medical consultant, who had a confirmed medical diagnosis and were later transferred to a medical ward were classed as definite medical patients. Some of the data was incomplete, however, and in those cases the patients were assigned to the category of "unknown". Furthermore, wards to which patients have been transferred have also been deleted but the transfer is indicated by an asterisk. On one occasion a patient was transferred to an emergency unit, which is designed to assess patients on admission and stabilise them and this is marked by a double asterisk. Although the conclusions drawn from the data are not entirely accurate (since the process of assigning patients to a given speciality required estimation in some instances) the data nonetheless provides a good indication of bed use and its implications.

This method of determining patient speciality is imprecise because a patient's speciality may change. This occurs not as a consequence of incorrect bed use, but because further investigations may reveal that a person admitted as a surgical patient may subsequently be found to have a medical problem (and vice versa). For example, in table 3.6 a patient was admitted with a rectal bleed. Because this could be Crohn`s Disease/colitis (medical condition) or neoplastic or diverticular disease (surgical conditions) it was impossible to assign a speciality to this patient.

Table: 3.5. Admissions to Ward A1: Medical, Orthopaedic or Unknown. July 1999.

Age.	Speciality.	Diagnosis.	Admission date.	Date moved.	Length of stay.
62	Medical.	Chest pain/shortness of breath.	14.7.99	17.7.99 *	3 days.
87	Medical.	Urinary tract infection/falls.	15.7.99	19.7.99 *	4 days.
89	Medical.	Bronchopneumonia, chest pain, anaemia	15.7.99	19.7.99	4 days.
62	Medical.	Deep vein thrombosis.	20.7.99	24.7.99	4 days.
78	Medical.	Deep vein thrombosis.	Unknown	Unknown	Unknown.
94	Medical.	Chest infection/pneumonia.	Unknown	Unknown	Unknown.
66	Medical.	Liver biopsy.	27.7.99	27.7.99	Day case.
62	Medical.	Hypoglycaemia.	22.7.99	23.7.99	1 day.
32	Orthopaedic.	Osteotomy of Phalanx.	27.7.99	28.7.99	1 day.
65	Orthopaedic.	Keller's arthroplasty.	27.7.99	28.7.99.	1 day.
?	Orthopaedic.	Open reduction and internal fixation.	Unknown	Unknown	Unknown.
71	Orthopaedic.	Fractured neck of femur.	28.7.99	Unknown	Unknown.

The mean age of persons included in the tables is 70, 61 and 57 respectively and this gives a mean age of 63 for persons admitted to Ward A1 between July and September 1999. It should also be noted that there were 28 patients admitted to the ward who had not had their details entered into the admission register. If these were taken into account, the average age would probably have been higher. Table 3.5 (above) details medical and orthopaedic admissions on a surgical ward. These are admissions that are inappropriately placed within an acute surgical bed. Table 3.6 (below) details a person who was admitted with a diagnosis of "social problems". Other diagnoses which perhaps signified inappropriate bed use were "unwell", "generally unwell" and "off his legs". Whilst such classifications may simply indicate unspecific language use by medical staff, which hides a real illness suffered by the patient, such language may equally indicate the inappropriate use of acute beds for conditions which may have been effectively managed on an

outpatient basis. Examples include headaches necessitating a stay of two days in hospital (table 3.6, below), an infected spot – a one day stay and a person whose migraine necessitated a one day stay. The practice of admitting patients to speed up access to equipment such as Magnetic Resonance Imaging (MRI) scanners was noted by Kibbler (1999) as was the practice of admitting elective orthopaedic patients until theatre time became available. The assertion that some persons are inappropriately placed within the acute sector is, therefore, supported by this data.

Table: 3.6. Admissions to Ward A1: Medical, Orthopaedic or Unknown. August 1999.

Age.	Speciality.	Diagnosis.	Admission date.	Date moved.	Length of stay.
52	Medical.	Difficulty swallowing.	4.8.99	16.8.99	12 days.
74	Medical.	Deep vein thrombosis.	4.8.99	5.8.99	I day.
94	Medical.	Unwell.	5.8.99	6.8.99	1 day.
44	Medical.	Generally unwell.	5.8.99	6.8.99 *	I day.
52	Medical.	Multiple medical problems.	6.8.99	7.8.99 *	1 day.
78	Medical.	CVA.	8.8.99	11.8.99 *	3 days.
69	Medical.	Obstructive jaundice.	9.8.99	11.8.99 *	2 days.
75	Medical.	Fainting episodes.	9.8.99	16.8.99	7 days.
74	Unknown.	Disorder of biliary tract.	10.8.99	16.8.99	6 days.
33	Medical.	Headaches.	11.8.99	13.8.99	2 days.
34	Medical.	Fits.	12.8.99	15.8.99	3 days.
69	Medical.	Social problems.	15.8.99	18.8.99 **	3 days.
74	Medical.	Chest pain.	16.8.99	18.8.99 *	2 days.
31	Orthopaedic.	Back pain.	16.8.99	18.8.99	2 days.
63	Orthopaedic.	Keller's procedure.	17.8.99	18.8.99	1 day.
68	Orthopaedic.	Arthroscopy.	17.8.99	18.8.99	1 day.
89	Orthopaedic.	Vomiting.	18.8.99	19.9.99	1 day.
37	Orthopaedic.	Unknown.	18.8.99	19.8.99	1 day.
65	Medical.	Cellulitis.	18.8.99	20.8.99	2 days.
64	Medical.	Chest infection.	19.8.99	27.8.99	8 days.
69	Medical.	Liver metastasis.	19.8.99	20.8.99 *	1 day.
57	Medical.	Chest problems.	20.8.99	20.8.99 *	<1 day.
63	Medical.	Rectal bleed.	22.8.99	29.8.99	7 days.
19	Medical.	Bacterial infection.	23.8.99	27.8.99	4 days.
73	Medical.	Dyspnoea.	23.8.99	27.8.99	4 days.
68	Medical.	Deep vein thrombosis.	24.8.99	28.8.99 *	4 days.

An examination of the admission register for the same period on Ward A2 provides a similar picture. The mean ages for July, August and September were 69, 68 and 57 respectively. This gives a mean age of 65 for selected persons admitted to Ward A2 between July and September 1999. The tables have not been reproduced here

since the policy of not including discharge and transfer dates during this period made the calculation of bed days lost impossible. Possible inappropriate admissions, however, included "headaches/neck pains" and "wheezing".

The calculation of bed days lost on Ward A1 was achieved by counting those days that a person who was categorised as a highly probable medical or orthopaedic patient spent on Ward A1. In total, therefore, the number of bed days lost on Ward A1 between July and September 1999 was 76. To this can be added a possible 33 days that four people spent on the ward but whose speciality was unclear necessitating non-inclusion of these figures. There were 24 medical patients and four orthopaedic patients for whom length of stay was not known. There were also five patients admitted to the ward whose speciality and date of discharge or transfer were unknown as well as one transfer from a medical ward who spent one day on the ward. For the purpose of this analysis and since no data was available to suggest otherwise, it was assumed that this person was an appropriate surgical admission since transfers from medicine to surgery are not uncommon (this also highlights the fact that patients are sometimes inappropriately admitted to medical wards). Patients who spent less than one day on the ward were also excluded from this analysis since it was impossible to quantify length of time to this degree. Calculation to the nearest whole day provides a sufficiently in-depth picture of bed use. Given the above, the figure of 76 bed days lost on Ward A1 during a three month period is likely to be a conservative estimate. This means that over a one year period Ward A1 loses at least 304 bed days, equating to 6.33 bed days per week. If Kibbler`s (1999, p.1) figures are to be believed, it costs £350 per bed day giving a potential yearly cost of £115,267. If this seems excessive Kibbler herself notes that "one patient incurs a potential cost of £4,900 for a 14 day delay. The weekly cost of 20 delayed discharges can therefore be assumed at £49,000, over 52 weeks this accounts for £2,548,000". The figures presented by Kibbler do yield the stated results although it is impossible to verify the accuracy of the initial figures. Participation in ward visits with the bed management team revealed, however, that on three occasions the numbers of delayed discharges were between twenty and twenty-five per week.

The inappropriate use of beds has, therefore, considerable financial implications for Trust A. The primary resource of beds affects all other aspects of resource management including staff, finances or time. The implications of bed use are highlighted by a notice in a magazine distributed within the Trust. It notes that there has been a noticeable rise in infection rates, which is attributed to increased pressure on beds and increased workload.

Trust A has been reported as being at "continued financial risk" (Core Brief 2000). Newsletters also point out that in May 2000 net trading deficits for the year ending 31st March within the Medical and Surgical Directorates were £35,000 and £145,000 respectively. There was an "over performance" in emergency medical activity. The Surgical Directorate was affected financially by "The increase in medical emergency admissions that resulted in the cancellation of significant numbers of elective inpatient work as surgical beds were occupied by medical outliers". In June 2000 "bed pressures" were again cited as a reason for the under performance of the Surgical Directorate, whilst in July there was considerable under performance again, "predominantly in General Surgery and Orthopaedic elective work".

3.5 Appropriate bed use and delayed discharge.

Having been admitted to the acute setting, it should still be possible to either discharge patients to a more appropriate environment once the initial phase of their illness has passed, or to transfer them to a more appropriate setting if it is subsequently felt that their admission was inappropriate. There should be enough flexibility to allow ongoing assessment and correct placement, safeguarding throughput whilst ensuring appropriate and safe management. This is not the case, however, and the following section will examine possible reasons for this mismatch between the ideal and the actual.

The introduction of monthly budgets by social services departments appears to have had an adverse effect on the ability to provide funding for the timely and safe discharge of individuals into the community. This restriction of funding places undue pressure on other parts of the service. Inability to utilise acute beds

appropriately means that rehabilitation wards and medical wards become full and this impacts upon surgical and orthopaedic wards that must use any spare bed capacity to accommodate outliers. Regarding the debate between more beds versus more appropriate use of beds, a medical consultant commented that "we don't need more beds; we need the beds that we've got to be empty". One social worker claimed that her caseload consisted of 16 residents from within the borough and six others and estimated that the backlog would cost £140,000 to clear. Because of the reduction in budgets and the consequent need to ensure efficient targeting there are a number of patients who are awaiting funding (to purchase their care), awaiting budget allocation (for a non-residential or domiciliary care package), pending (yet to be allocated a social worker), or whose applications have been frozen (temporarily halted).

The local council in its "Proposal for Waiting List for Placements" (date unknown) recognises that there is now a serious overspend as a consequence of which cases must be prioritised depending on urgency of need. Priority one cases are those who are likely to be at risk of serious harm if not placed immediately. Since the hospital is deemed a safe place, as the authors admit, "there will be a major impact on hospital discharges…there is a danger that this could lead to an increase in unplanned hospital discharges which will then become priority one cases…" One ward manager commented that hospice places were weighted in favour of those patients who were experiencing difficulties in the community rather than those who were awaiting discharge from hospital.

Bed managers were approached in the light of this to ascertain the degree to which emergency readmission rates are affected. At this time, however, staff did not routinely audit readmission rates although one bed manager did admit that "the same names keep cropping up". Both hospital and community staff conceded the possibility that patients are either discharged too soon or readmitted because of "faulty discharge arrangements". Hence there is a drive to develop alternative strategies to minimise expenditure. Key areas identified were "continuing care, rehabilitation, reviews and reassessments of existing users against new access criteria, charging policy…and recommendations for nursing home provision from health care professionals". These attempts to curb expenditure through the

redefinition of need have effects throughout the discharge planning process since, in redefining need, many individuals may find that they do not fulfil access criteria for their next placement. This problem is highlighted in Kibbler`s (1999) appropriate bed occupancy study in which it was noted that the vast majority (66%) of delays in discharge were of a social care nature (see table 3.7, below). In fact, the figures suggest that the actual percentage of patients who may be classed as being delayed by social care arrangements is between 53.2 (based upon categories 1, 2, 3, 4, 6, 7 and 9) and 69.3 (if additional category 14 is included). Those requirements that are of a social care nature have been marked with an asterisk. Continuing care has not been included since continuing care remains a health need although social workers frequently have input into this area also. It should also be noted that lack of facilities to cater for specific patient needs is a factor in limiting the removal of inappropriate admissions from secondary care and that social workers cannot be blamed for underinvestment or poor planning. Category 14 (step-down) is ambiguous since social workers may or may not be involved in these arrangements (although it is customary to request their permission beforehand). The situation, however, varies between Trusts.

Table: 3.7. Reasons for Delayed Discharge from Acute Care in Trust

A.

Reason.	Number.	% (to 1 dec.pl)
1. Nursing/residential home placement.	1	1.6 *
2. Social work allocation.	15	24.2 *
3.Budget approval.	1	1.6 *
4. Piper alarm.	1	1.6 *
5. Outliers.	3	4.8
6. Rehabilitation	7	11.3 *
7. Rehabilitation out of area.	3	4.8 *
8. Continuing care.	2	3.2
9. EMI	5	8.1 *
10.Medical team review.	8	12.9
11. Diagnostic results.	2	3.2
12. Access to MRI.	2	3.2
13. Cancelled surgery.	2	3.2
14. Step-down.	10	16.1 *
Totals:	**62**	**100**

Kibbler also noted the length of time it took for patients to be allocated a social worker – her research revealed an average of 11 days. Kibbler`s findings seem to understate the problem since findings from data analysis show allocation times ranging from 18 to 36 days in some instances, the average being 28.5 days.

Staff at Trust A have acted upon recommendations to improve bed utilisation and the targeting and funding of individuals. In accordance with DOH directives (DOH 2000(a), 2000 (b), 2001) the establishment of Primary Care Trusts (PCTs) has meant that Social Services Department staff have now relocated to specific areas in the community, providing services for GPs. There is now a small number of staff remaining within the acute facility to deal with queries from public and staff. There is also a discharge tracking service being piloted, which is likely to become permanent. This provides an outreach service and a point of contact between community and hospital in an attempt to audit discharge practices and reduce readmission rates. The NHS Booked Admissions Programme is also being rolled out across the Trust to make access to Trust facilities by patients and GPs easier and reduce the incidence of cancellations and Did-Not-Attends.

One of the wards within Trust A has reopened as a nurse led step-down facility with twenty-eight beds which can accommodate patients who are medically fit for discharge but are delayed by care package arrangements or waits for equipment. A new psychiatric facility has also been built which may mean that those older persons will receive more appropriate and timely treatment in this regard since Trust A will not be reliant on out of area facilities.

Trust A undertook a survey of 5,600 patients and found that those activities such as journey to, arrival and reception at the hospital, food, bathroom and toilet facilities were rated highly satisfactorily by patients. There was, however, no mention of discharge arrangements, information giving and communication practices. This suggests that either these questions were not asked or that there is still some improvement to be made in these areas.

3.6 Rehabilitation services.

One of the principal reasons for delayed discharge is that people stagnate within the acute care setting because there is nowhere else for them to go (see I1A). Nursing home beds have been reduced in number and rehabilitation beds are at a premium. The West Midlands region is acknowledged by the National Audit Office (NAO) to have capacity problems in that 17% of delayed discharges are attributable for waits

for care homes and that 24% were still awaiting needs assessment – an earlier stage in the care pathway (NAO 2003, p.37). In Trust A there is a sister hospital which specialised in rehabilitation (covering the south of the borough). This facility has approximately 119 beds and one ward, which was closed for much of the time but used to ease winter pressures. This ward has since been reopened. Of these beds ten are designated as step-down although the number of step-down beds has increased with the opening of another step-down facility on the main site. Step-down beds are intermediate care beds, which are used when the patient is no longer in the acute phase of their illness and needs convalescence and rehabilitation rather than intensive medical input. Intermediate care in the north of the borough is provided by a local authority funded home. There is also a stroke rehabilitation ward, which is located at the main site (in accordance with best practice guidelines). Social Services provide 306 beds in eight homes whilst the independent sector provides 463 beds in 22 residential care homes and 844 beds in 21 nursing homes. There is also a great reliance on private sector care homes, as well as nursing home beds rather than residential home beds according to the Department of Public Health (1997, p.60), which is supported by Social Services Department's activity analysis document (1998-99, p.23-24). At the end of March 1998 this borough had the lowest number of persons over 75 in residential accommodation with 39 places per 1000 population (the metropolitan average is 68). Given that these persons are more likely to suffer long-standing limiting illnesses, the reliance on nursing home beds is understandable and yet the number of independent sector nursing home beds has declined nationally. This gives rise to questions concerning the placement of vulnerable individuals following hospitalisation since a reduction in nursing home beds may mean that residential homes suffer inappropriate placement of those patients who require nursing home care.

To this end, the staff of Trust A are currently examining new initiatives to ensure appropriate placement of patients on discharge and to prevent admission or readmission to hospital. As the Department of Health (1997) noted, a combined approach will probably be needed. The possible options are:

- "A low dependency facility for people being discharged from hospital awaiting the nursing home of their choice or waiting for the completion of home

adaptations, or people not requiring medical care but needing to be nursed on a short-term basis" (p.60). This is the role of the step-down facility.

- "An aggressive rehabilitation facility – for people being discharged, or as a respite care admission or to prevent admission to a general hospital bed" (p.60).
- "A `slow track assessment` process giving people a fixed-term four week spell in a nursing home funded by the NHS on discharge from hospital. This period will enable further rehabilitation and assessment out of the hospital setting and may be better able to determine whether the patient could go home or would need continuing care…" (p.61).

This illustrates some of the problems in the translation of an idea into practical use. The concept of step-down was seen as a positive step but enthusiasm has waned with the realisation that it is difficult to get patients into this facility. Partly because of the low number of step-down beds there are strict criteria for admission. These are:

- The patient must be in the acute facility of Trust A, regardless of residency.
- The patient must be medically stable (temperature, pulse, respiration, blood pressure, haemoglobin, urea and electrolytes, coagulation and blood sugar measurements).

They can be:

- Elderly medical patients needing recuperation or confidence building.
- Orthopaedic or surgical patients who are seven days "post-op" requiring a little more time prior to discharge.
- Rehabilitation patients who have reached a plateau (less intensive services needed or awaiting residential home placement).

This illustrates the point that it does not matter what speciality a bed is assigned to. If there is not enough spare bed capacity within the system beds will be used for other purposes or will not exist in sufficient numbers to meet demand and this will

cause backlogs within the system (Bagust, Place and Posnett 2000, see p.7-8). Nurses felt resentment at the length of time some patients spent on the ward. The phrase "dumping ground" was used twice and another nurse commented that "it's like an old people's home" (I3A). Nurses feel that they cannot discharge patients and come to resent the fact that the rehabilitation wards are seemingly always full. This is not helped by the fact that step-down assessment staff can refuse patients. For example, a patient on Ward A1 had been assessed and found to be unsuitable for step-down. The ward manager said that because there was pressure on that part of the organisation also, it would be inappropriate to accept that person because that person would simply be stuck there. In another instance a patient was accepted for rehabilitation but when it became known that he was confused the offer was withdrawn because he was not "technically rehab-able". There have been instances of patients being refused step-down or rehabilitation because of their medical problems and the staff involved say that they have had to fight to prevent step-down beds becoming simply a convenient point to off-load patients. This raises questions concerning definitions of medical fitness held by acute staff and community or rehabilitation staff (this concept is discussed below).

The situation is further aggravated by the fact that both patients and relatives may refuse step-down, opting instead to remain in an acute bed. Nursing staff feel that people should not be allowed to become "bed blockers". One staff nurse was heard to say "I'm just not sure this lady should be allowed to dictate where she goes" (I7A). One nurse opined that patients should not be allowed to refuse to move to a more appropriate environment because this represented an extension of hospital facilities (I3A, 706). The eligibility criteria state, however, that the patient, relatives and consultant should all agree to the transfer. Reasons for refusal include the distance involved in visiting a patient and the inconvenience of having to move twice – once to step-down and once to the home of their choice

It is noticeable from critical incidents that this happens more to those persons who have medical or surgical problems but who also have some degree of mental illness. Kibbler (1999, p.7) concurs. She notes of the frail older person that:

> *"This group of patients do not seem to fit in either medical, rehabilitation or step-down. They have complex health needs and are `up and down` in terms of their general health. There appears to be some merit in grouping these patients together under the care of an elderly care physician, where their long-term needs can be assessed in a slower track environment".*

The same point was made by a member of the step-down team who asserted that patients were readmitted with problems that should have been anticipated as a logical corollary of the presenting problem. The point was made that care was segmented and that proper holistic assessment of all needs should be undertaken by, for example, joint management from orthopaedic and elderly care physicians (who currently decide whether a patient is fit for step-down or rehabilitation). This person claimed that the older person may have their broken bones treated but the underlying cause remained. As this member of staff put it "people don't just fall over".

Having discussed patterns of bed use within Trust A as a consequence of population structure and the reasons why people are inappropriately admitted and then remain within the acute sector for longer than is necessary, attention will be turned to those factors which operate at the level of the ward or department. These sections are concerned with referral mechanisms, access criteria and the roles of nurses, doctors, social workers, specialist nurses and discharge planning sisters. The following section will detail nurses` definitions of the discharge planning process.

3.7 Definitions of the discharge planning process.

Definitions of the discharge planning process given by nurses are extremely important as a first step in making apparent the underlying process as it operates at ward level. It will be noted that the definitions, taken as a whole, are variable and this gives some indication concerning the exactness and timeliness of their application. Nurses uniformly expressed the belief that the discharge planning process should begin on admission. On those wards where pre-assessment was undertaken, this was seen as an ideal opportunity to commence discharge planning I7A, 755-760, I1A, 21-23). At its simplest level discharge planning was identified

as "highlight problems, refer, await solution" (I3A, 17-18) or identifying problems a patient may have on discharge from hospital (I1A, 12-14). It was evident throughout, however, that the time that support should be provided was open to varying interpretation such as "providing them with more support when they get home" (I1A, 13-16). Throughout many of the definitions, however, two principal themes were apparent. The fact that discharge planning existed to move patients from hospital and keep them out " …hopefully shortening their actual stay in hospital" (I1A, 13-16) or "…that's where the problems occur isn't it? You haven't planned for somebody to move on and you can't get them out" (475-477). "…If the patient hadn't had any input but I felt they would require it because its repeated admission where they've come in with the same problem and they're not getting the help…" (I3A, 9-17). Implicit in this last statement is the fact that current discharge planning arrangements may not always serve to maintain people in the community (I5A, 121-124, 128). The safety and timeliness of discharge planning was mentioned in only one interview (I6A). The majority of definitions volunteered tended to focus on the practical issues of discharge planning. It was also considered important that members of the multidisciplinary team should work together to provide a product and be responsive to the needs of the patient, "all working together and documenting in one place and being involved" (I3A, 250-252).

The second point is that the locus of control in the discharge planning process seems to have moved away from the nurse such that the nurses` definition of the discharge planning process encompasses the process of assessment to indicate need and then activation of referral mechanisms (I7A, 5-14. I6A, 24-33. I5A, 6-12). The following section is concerned with nurses` perceived fragmentation of service delivery

3.8 Fragmentation of service delivery.

Nurses occupy perhaps *the* pivotal role in the discharge planning process. This is so by virtue of their continued and close proximity to the patient at all stages of the person's illness and because of the primary position nurses occupy as referral agents, the vital link between patient, family and those other agencies, which provide or will provide care. .As, however, the locus of control in the discharge

planning process moves away from the more traditional nurse-centred model (as perceived by nurses themselves) a number of specialist nurse roles have been established. Specialist nurses include Discharge Planning Sisters, Macmillan Nurses, District Nurses and those nurses who specialise in the care of patients with specific conditions such as Respiratory Care Nurses, Stoma Nurses, Breast Care Nurses and Urology Specialist Nurses.

Fragmentation (the disruption of seamless care delivery) consists of two elements. The first is the practical consequence of too many people being involved in tasks related to the discharge planning process, whilst the second is related to the degree of affront the nurse feels at seeing their traditional remit being usurped or undermined by members of specialist teams. One nurse felt, for example, that having nursed patients through the acute phase of their illness she should have had more input into the discharge planning process. The perception seems to be that nurses felt that their role was either misunderstood or that specialist nurses took over those parts of the nurses` role that were glamorous.

One nurse claimed that the centrality of the nurses` role in the discharge planning process had decreased (I1A). A ward manager expressed misgivings with the state of the discharge planning process, claiming that the more people there are involved in the process, the longer it takes to sort anything out. Another nurse said that she found the discharge process confusing because some discharge planners deal with levels five and six of the access criteria and some deal with levels one to four. The consensus seems to be (as echoed by another ward manager) that discharge planners deal with cases requiring a large input from nursing and health rather than social care. The haphazard nature of working practices among the discharge planners was highlighted by a nurse who said: "…some of the Discharge planners arrange District Nurses and don't need a letter, others want you to organise District Nurses and send the letter, some want you to book an ambulance, others will arrange the ambulance…" (I3A, 303-306).

Other nurses felt that there were too many people involved in the discharge planning process and whilst conceding that the specialist nurses do arrange discharges effectively, pointed out that "…they do it effectively but I think

sometimes tread on each others` toes and sometimes the patients will actually say `there's a lot of people coming and going`. So I feel...that they're overlapping and they're involved before they even need to be" (I3A, 512-515, 257-264, 437-448, 302-303, 126-129, 389-393) or, "Some of them are very quick, very thorough and sort things out" (I3A, 342-343). This nurse felt that the specialist nurses exercised saturation techniques in picking up referrals and that this prejudiced the giving of individualised care (I3A, 459-467). Concerning this last point, one Macmillan Nurse commented that she had known instances where nurses had not referred terminally ill patients to the relevant specialist service because this would result in a delay in the discharge.

The same nurse also felt that her expertise in assessment was being questioned because a specialist nurse was:

> *"...organising special mattresses and cushions and we assessing the Waterlow knowing they don't need them...and I said that the Waterlow`s not showing that and they don't need it while they're on the ward so why are u discharging with them. Well they may in the future" (I3A, 257-264).*

The discharge planners pick up referrals from ward staff thus respecting to some degree the nurses` centrality but the other specialist nurses pick up referrals directly from the medical notes, bypassing the nurse. The nurse felt that it is not within the specialist nurses` remit to decide at what point specialist intervention is necessary. This was seen as part of the traditional role of the ward nurse. The nurse also felt that discharge planners were involved too early and regretted the fact that much of the discharge planning process is being monopolised by specialists:

> *"I just feel we took a step back ...a terminal patient now you know when they come in you don't have to refer to any. If it isn't specialist nurses in that role like breast, bowel, urology, if it isn't them it's Macmillan's and discharge planners...sometimes you get a bit mixed up in what they're actually doing. I'd like them to assist and all work together..." (3, 318-319, 272-275,* 282-283).

It was also evident that nurses felt that whilst specific client groups benefited from the intervention of community-based nursing services, others did not. One nurse

claimed that whilst the service provided to terminally ill patients was excellent, it was difficult to get a discharge planner to see a patient "unless they're dying" (I3A, 99-101) and that "...other patients who could do with other input aren't getting it" (I3A, 286-287). The same nurse commented that "it's these little old ladies that come in, live alone, confused, can't go back to the house, got no family...that's when we start hitting problems" (I3A, 130-132). The nurse also asserted that discharge planners were difficult to refer patients to because they seemed to avoid certain patients by claiming that "I think that's a social worker's job" (I3A, 303-306). The following section is concerned with the administrative burden, which appears to be inherent in the discharge planning process.

3.9 Paperwork.

Nurses perceived that the nature and amount of documentation has changed. Previously, both the discharge process and the documentation associated with it required relatively little effort. "The doctors used to send their letters to the doctors, used to give them their outpatients` [appointment] and that was it. We never gave them any documentation years ago when I first started". Now, however, "documentation, there's a bucket load...the hurriedness of it" (I9A, 695-712). This causes frustration among nurses.

> *"I get very frustrated and I thought I've come into nursing to give patients a nice bed-bath, dress their wound, help feed them, do their drip, look after their drains, look after them post-surgery. I never realised how much time I would be on the phone and writing..." (I9A, 358-362. I3A, 23-25).*

One nurse commented, in contrast, that the amount of paperwork that nurses had to complete has actually diminished although there was more paperwork from social services staff than the discharge planning nurses (I1A, 79-98).

Although the amount of documentation concerned with admission and initial assessment has increased, nurses perceive that this does not necessarily indicate a corresponding rise in standards of care. "And then you write in this little box the date, what shift you're on and you sign your name. At the end of the shift the next

person will come on, they've probably not even looked `well the clips are due out on this date, I'll just sign the box anyway`" (I9A, 415-422). The more experienced nurses commented that the assessments that were done during their training were as good as the assessments being carried out now but without the need for large amounts of paperwork (I9A, 364-375). Indeed, the need to fill in documentation and perform administrative duties was felt to be a key factor in the inability of senior staff to perform direct care thereby passing on experience to more junior colleagues. The current practice of initialling boxes on care pathways or core care plans, irrespective of whether an aspect of care has been performed, was felt to impede both assessment and education unlike the older process of manually writing care plans. Interview I9A indicates that the participant felt that one method of overcoming deficiencies in the current care planning system was to introduce care planning documentation which took account of the individual situation of wards – more paperwork to solve the problems created by too much documentation. The respondent also noted that it made little difference what documentation was introduced since staff will either not act on it or not ensure its completion to a satisfactory standard I7A, 395-413).

Documentation is seen as necessary by nurses. Indeed, one participant (I1A) commented upon the inadvisability of returning to the old system. Joint documentation (in which all staff enter information into the medical notes) was seen as a positive improvement (I1A, 114-117) although one nurse commented that there is still an unacceptable amount of duplication caused by the practice of documenting on the observation charts, in the medical notes and on the care plan (I6A, 367-282). Too much or too little documentation was seen to be prejudicial to the maintenance of care standards as it either precluded direct care or failed to provide nurses with enough information regarding previous treatment. Just how serious this lack of documentation can be was highlighted by one respondent: "We've had a couple of patients admitted to the ward who've had no documentation done and no care as such they would expect to receive on the ward. We had a lady admitted who hadn't had a treatment sheet for two days and when she was admitted up she was hypothermic, hypotensive. She died four hours later" (I1A, 443-437).

Nurses` over-reliance on documentation was perceived as an aid to deflect litigation and the need to "cover our back" as evidenced by comments from a nurse who claimed that "…it came to the point where I was petrified I'd lose my number. I love nursing, I love being a nurse, I love the patients. But the expectations of the patients, you have to write more which takes you away from the bedside…" (I9A) and further "…and with the paperwork, with direct nursing care there's too much. I know from a legal point of view its necessary…" (I6A, 367-368). Finally, the same nurse added:

> *"...they're frightened about accountability...about any repercussions from that. A patient complains for instance and the first thing they do is look in the notes, find out who's looked after them at a given time and also going back to the training. They're taught now that everything's got to be documented one hundred percent and again I've got no problems with that, you have got to document the important bits, but they're not taught to discriminate. Sometimes people are just writing reams in the notes of irrelevant stuff and that's the mentality at the minute...they're not distinguishing priorities and they're not identifying the important parts".*

There is also misunderstanding concerning the correct use of aftercare (AC) forms by nurses. There are 17 such forms governing all aspects of care arrangement. The forms are perceived as requiring too in-depth information and not being user friendly. There is also confusion regarding whose responsibility it is to complete these forms and instances arose of social workers duplicating the form that nurses had already filled in (pointed out by a staff nurse with some chagrin) and of forms getting lost. Of these forms one staff nurse commented: "we have enough to do without the AC form filling as well" (I3A, 54-57).

> *"We have to do the assessment AC1 which I don't feel very comfortable with really because it's a detailed form and I never understand it. I find the form is very key linked, its got an index to itself...Certain codings have got to go in certain boxes that's why we are always having them returned because they are completed inappropriately" (3, 42-49.*

Further she stated:

> *"I personally think that the AC1 in particular is just a very in-depth form and the information is so limited what you can put on it, cos you want to explain the situation...cos they actually ask you mobility and how and competency but they don't give you anywhere to write anything. It's just all letters. I find the AC1 very letter orientated, not explanation, patient, nursing orientated" (**I3A**, 76-80).*

Another nurse commented that although she would have liked more input into the discharge planning process, form filling was seen as a hindrance "because you just haven't got the time. That's why some discharges are delayed a little bit because you haven't referred on time or you haven't filled in the right forms" (3, 61-63). Having explicated staff views concerning the amount of paperwork they must deal with, the following section is concerned with the interpretation of access criteria through selective use of language.

3.10 Use of resources or system and interpretation of information/language.

This section deals with access criteria, referral mechanisms and the use of language in interpreting the needs of service users. Access criteria are divided into six levels of need. Of these, levels three, four, five and six are classed as complex according to the literature. In practice, however, it is levels five and six that are taken to denote complex needs as these levels encompass both nursing and social input over a prolonged time period with associated financial commitments. Health authority and social services must provide funding to different degrees at each level of need. Level one need would be met predominantly by social care funds, whilst level six represents full funding by the health authority. Thus the levels represent increasing need for nursing care, care which is provided by a bewildering array of services each with their own access criteria including rehabilitation services, community health services, specialist palliative and terminal care services and respite services as well as many others. In a directory of services provided within the region there are listed 188 GP practices, 24 women's` support services, 35 services dealing with physical disabilities, 28 terminal care and bereavement services, as well as 97 homes and support services for the older person (excluding mental health support for the older person which has its own section), carer support services, ethnic minority community care services, transport and day centres and lunch clubs.

The most important point to note, however, is that all levels contain elements of both nursing and social care although this is dependent upon the context in which care is carried out. The precise nature of the relationship between health and social care causes confusion among members of staff who must decide who they are to make referrals to. Part of the reason for this confusion may lie in the fact that the definitions used in the access criteria are vague and generalised. This ambiguity transmits itself throughout the referral process. Nurses in particular are unsure whether a person's needs fall under the remit of social workers or discharge planners. One staff nurse, when asked if there were any negative point concerning the discharge planning process, replied:

> *"The only thing I can think of is establishing the levels for patients because if they're a level six they fall under the interim [sic] of the discharge planners and for instance if they're a level five or below, they tend to fall under the social work department...So when you've got somebody who's borderline five or six we do get a lot of wrangling about...from the social work department whose...which level they come under. So we get pressure sometimes to say, you know, `they're a level six as opposed to a level five` and its quite difficult to distinguish between the two sometimes" (**1**, 113-119).*

On average each complex assessment requires that three forms be completed (AC1, AC2, AC4). Social workers readily admit that nurses have not the time to fill in these forms but assert that it is their responsibility because the form constitutes a nursing assessment of need. This raises the question of involvement of social workers in assessment of nursing need and it would seem that since payment for needs comes from the Community Care budget then the social worker must ratify funding.

There is other evidence of misunderstood referral procedures. Of the referrals that the District Nursing Service received in November 1999, 22% of these were judged to be inappropriate which represents a considerable drain on resources. The Occupational Therapy Department has recently had to restrict access to its services to those persons who are soon to be discharged and those persons who have undergone amputation because of the large number of referrals received and consequent pressure on staff. During periods of high admission rates, nurses in the acute sector feel that any patient who has nowhere to go will end up in hospital

whether their admission is warranted or not. Two managers asserted that GPs abuse the referral system in that they send patients to the Accident and Emergency Department with what are perceived to be non-existent or trifling illnesses. The person then becomes a social problem. During data collection it became evident that nurses used the concept of inappropriateness in two distinct senses. A patient could be classed as an inappropriate admission because they were perceived to be a social problem and should not, therefore, be in hospital at all. A person could also be classed as an inappropriate admission if they occupied a bed in what the staff considered an inappropriate speciality. The picture that emerges is one in which all elements of the service are placed under increased pressure. All services involved in discharge planning have seen increases in the number of cases and their complexity. The situation has also been obfuscated by the increasing number of specialist teams now involved. This creates confusion as to what is required when referrals are made and creates an environment where ward-based staff feel threatened by an incremental change in their roles and a shift in the locus of control away from the more traditional seats of power. All these factors cause conflict. How such increased levels of pressure, change and uncertainty are dealt with is crucial to an understanding of the relationships between those disciplines involved in the discharge planning process and ultimately, therefore, to patient outcomes.

One consistently used method by means of which financial pressure and workload pressure is reduced is the interpretation of access criteria by the professions involved. The interpretation of access criteria in a manner that favours one's own profession allows some of the workload to be deflected. It is also used to affirm group values and solidarity (in part by the castigation of outsiders). In its various forms this phenomenon was witnessed in paediatrics, surgery, medicine, the Discharge Planning Service and social work.

The phenomenon of gate keeping is the practical manifestation of groupthink (Irving 1982). This is the process whereby members of a group come to subconsciously define the values of the group, deal with heterodoxy, and refuse to consider possible alternative courses of action. Through groupthink group solidarity becomes greater but a price is paid in terms of the ability of the group to respond flexibly to new and unanticipated demands. All anomalous data is

interpreted solely by reference to the group's established (but inflexible) value code. Groupthink engenders a limited view of events and a defensive posture. Groupthink also presupposes a moral element, which is used both to censure nonconformity and to cement the group. The moral element (based as it is on limited information) is almost certainly inaccurate but this is not the point. Gate keeping may be defined as the control of group resources through reference to the belief codes of the group. Key beliefs are that resources are finite and that staff should be impartial (this is particularly important when members of the group define medical fitness). The second belief is, however, used to mask real group motives and is used to rationalise inconsistencies in group outlook in order to serve group interests through a system of informal and formal organisational rules. During data collection, these justifications had a purely parochial aspect in that, on occasions, they only seemed to apply to the clinical area in which the participant was working. Thus, physical and geographical limitations may serve to increase the prevalence of groupthink and hence gate keeping practices.

A recurrent theme was the discussion surrounding medical fitness/unfitness of patients. There was some latitude in the assigning of these categories and nurses and social workers will attempt to achieve consensus over meanings through negotiation. The two professions each try to defend their version of reality until agreement is reached. The stakes are high. If the social worker outscores the nurse then the social work department is saving money since the person must remain in hospital and workload is eased. This may also be a defence mechanism in that this encounter provides an opportunity for the social worker to express dissatisfaction with the nursing service in a formal setting thereby restoring the balance of power. If the nurse wins then a bed becomes available and throughput can be maintained.

On one occasion when a patient was placed in a disputed category the social worker exclaimed "Oh no, I'm not playing that game". Two examples of the way in which the category of medical fitness was applied may help to illustrate the point. A female patient was declared to be medically fit by the nursing staff. The social worker read her notes and pointed out that she had been unwell the previous weekend. The nursing staff insisted that it was nothing serious and that it should not be allowed to interfere with her discharge. The second incident resulted from a

lady being declared medically fit whilst still receiving intravenous fluids. When questioned, the nursing staff conceded that she had become a little dehydrated but that this should not interfere with discharge arrangements. The term "medically fit" can, therefore, be used to label those patients who are deemed to be inappropriately placed on the ward in order to bring pressure to bear upon social services, discharge planners and bed management in an attempt to regain control over resource distribution. It may also serve to justify withdrawal from a patient who is no longer seen as deserving. The appeal of such terms may lie in their very vagueness, there seems to be no mutually agreed verifiable method of assessing medical fitness.

Kibbler`s (1999) assertion that the frail older person is difficult to categorise may aid the process of gate keeping ensuring that the term "medical fitness" remains difficult to apply with preciseness. Some departments insist on stable physiological parameters (step-down) but stable for how long? Many older people's health constantly fluctuates. The use of terms such as "dumping ground" may suggest that nursing staff feel unhappy about caring for those patients from a different speciality or patients who are adjudged to require little care (Allen 2001). No throughput of patients may diminish nursing morale, hence the practice of labelling to have them removed.

This is supported by findings from the data. One staff nurse described herself as feeling frustrated because patients had nowhere to go and described the situation as wasting resources. There are other examples of the use of language masking the power and resource control debate. Another example of this interpretation of medical fitness in an attempt to influence the control of resources was recounted by a social worker. She said that social workers from the "fast track team" have been called to Accident and Emergency to assess individuals who have been categorised as functionally independent by health care staff. The social workers found that, in one instance, it took two people to lift the patient. On a strategic level this tension is also evident. Is it coincidence that simple assessments carried out by social service personnel have decreased by 20% whilst the number carried out by other health care agencies have increased by 21%? A specialist nurse asserted emphatically that she had known cases of nurses not referring patients to discharge

planners or Macmillan Nurses because the ward nursing staff felt that this would result in delays.

At a multidisciplinary team meeting one person was noted to require minimal assistance with her Activities of Daily Living (ADLs) according to the Occupational Therapists who carry out this functional assessment. The doctor present interpreted this to mean "independent with ADL" and added "if we keep this lady for 365 days we will have 365 different complaints". This lady's medical fitness was reinterpreted and presented in a manner which favoured the discharge of a patient who was seen as unpopular, undeserving and, therefore, inappropriate. By contrast, another lady was said to be mobilising with some assistance and yet was also deemed to be independent. She was described by the doctor as a "very pleasant lady" and the general consensus was that she required more time. This despite the fact that she had reached approximately the same level of functional capacity as the first lady but was not as unpopular.

The use of language may also act as a barrier to input among health care staff by impeding communication or by impeding access to resources. Of the social workers one staff nurse commented that:

> *"They just boggle us with science like the finance has gotta come from so and so...so we don't have much input from them. The discharge planners we can because we can question them because we actually know what they're usually on about. So I feel we have a bit of input there and with the specialist nurses you can question them if you don't agree with what they said" (3, 698-703).*

An understanding of the language of a discipline enables a clearer understanding of the processes involved and this in turn confers a degree of power since it enables dialogue concerning resource allocation in the discharge planning process. The final example was taken from a delayed discharge form, which each ward manager is obliged to complete on a weekly basis. A patient was admitted with a diagnosis of constipation on 5th October. According to the nursing staff, she was declared medically fit on 14th October and was referred to the social workers on the 15th October. On the 20th October she was still awaiting social work allocation. The reasons given for the delay in discharge were that the patient was unclear about

what she wanted at first and was also still complaining of being in pain. It should be noted that some evidence was found to suggest that there is a hierarchy of illness, which dictates the perceptions of the nursing staff regarding appropriateness and deservedness of admission. One of the illnesses that confers upon the sufferer the status of undeserving is constipation. Others include illnesses that are seen to arise as a consequence of self-neglect or mental illness. Thus there are two senses of the term "inappropriate" (highlighted above), namely that a person should not be on this ward (weaker sense) or that they should not be in hospital (stronger sense). This impacts directly on staff workload and, therefore, levels of stress (discussed in the following section). If language and interpretation of access criteria can be used to deflect persons away from a department then workload and levels of stress will be reduced to the benefit of the occupational group concerned.

3.11 Workload, morale and standards of care.

Stress and the inability to guarantee sufficiently high standards of care are extremely important mediators of staff morale and satisfaction. Staff interviewed perceived that the nature of nursing was changing and that workloads were increasing. Comments included the fact that crisis management was the norm, "struggling with not enough staff…a struggle with patient throughput", I think the ward nurses have been very busy…I do empathise with them" (I2A, 453-454, 461).

> *"Often I feel sort of a lot of people haven't got the time, that everybody feels pushed and pressurised. You talk to some people like discharge planners and their workloads are tremendous...and sometimes when...somebody comes back into hospital they've not delivered what's been promised. You know, they are expecting things that they have been promised in hospital and what we've been led to believe they will receive hasn't matched up to what they've received when they've been in the community"*
>
> *(Charge nurse,I5A, 101-108).*

The charge nurse commented further:"It's a pain in the a**e. It's a nightmare. There's so much pressure to get them off [the ward]…" Other comments included the impact of limited time (I5A), staff shortages (I2A, 117-121, I1A, 462-469) and increased dependency of patients as more routine surgery is moved from hospital at an earlier phase.

"Staffing levels are far from adequate...dependency levels are higher but staffing levels have reduced but a high quality of care is expected and relatives are encouraged to complain if this quality isn't met. There is no job satisfaction compared to twenty years ago. There is only stress and frustration" (D Grade staff nurse, written response).

A sister commented:

"We had HDU [High Dependency Unit] patients on our ward and you could be a nurse on your own with ...two, three colorectal major ops. That's not fair, but you wouldn't have had that situation ten years earlier because you had your haemorrhoids in there, your pilonidal sinuses. Whereas now, because we get them out earlier, get them out quicker, get them into community, do hospital at home whatever for the first seven days, which is all about improving service for the patient. Get them out of hospital, make them better, your dependency goes right up" (I9A)

"I know that sometimes even post-Hartmann`s procedures, once they1re independent, they're out with their stoma care. Whereas before it would be we1ll see how they get on...another week...two weeks. I know that a friend's mom has had a hysterectomy and colposuspension done and was out within three days...abdominal hysterectomy, total abdominal hysterectomy, how scary is that? We have `calpos` on here and they're either discharged with the catheter or they have the catheter in a good five, seven days" (I9A)..

Interviews with other ward staff on this particular ward revealed that, due to its specific nature, staff were being asked to take on an increasing workload by managers in order to ease bed pressures and ensure that elective commitments were met. This situation was not helped by the fact that managers appeared to have gross misconceptions about certain aspects of nursing care in relation to specific procedures and clinics and, therefore, underestimated the nursing workload. No interview segments can be provided to verify this in order to maintain anonymity. There seems to be an inherent tension between management goals, as perceived by nurses, and the compatibility of those goals. Whilst agreeing with the need to prioritise, one charge nurse saw management as being concerned with "high throughput of patients, high maintenance of contracts, reduction in complaints, reduction in clinical incidents, reduction in accidents at work" (I6A, 574-578) but acknowledged the problem of ensuring correct skill mix in such a climate.

Also, a relationship was revealed between high workload and low morale. A sister commented that her morale was adversely affected. "I think its getting worse…I can't wait to have babies, come back part-time and have no responsibilities". She added that:

> *"It upsets me to think that I don't want to do it anymore after all the hard work that I1ve done but I think that because I get so wound up by even the littlest thing now, I think `God, I shouldn't be doing this`. You know, I set myself high standards, I expect everybody else to work at that standard...You see some people coming into work, don't give a shit what they're doing here, don't do a thing, can walk off the ward and get paid and then you see yourself running around like a blue arsed fly getting everything done, trying to make sure everything else is OK..." (I9A).*

Another nurse felt that the more one became exposed to the intricacies of management and the more time one spent within the NHS, the more one worried.

Of further concern to many nursing staff was the perceived inability to maintain standards of care. One sister commented that "management has increasingly made the discharge of patients a high priority…compromising the care of the acutely ill and high priority patients such as pre and post-op patients. This has become a source of great stress to nurses" (written response) or:

> *"Frustration really, because I would like to deliver better standards of care and have a more intimate relationship with the patient you look after, spend more time and get to know them as people rather than as a product and a number...sometimes I feel that we cant deliver enough or we just cant spend that extra little bit of time" (I5A, 41-43, 47-48).*

One nurse provided a graphic example of poor care caused by the need to discharge patients quickly:

> *"Its like this lady who came up, dry pads, sterile pads is all they [tissue viability nurses] told us to put on...You know what we were actually told? That the District Nurses had a better knowledge of wound dressing, let them assess...I'm so embarrassed to say that this lady has been seen by tissue viability and all she's going home with, with a fungating breast lesion, is dry sterile pads tucked in her vest or in her bra..." (I9A, 908-918).*

Nurses were also concerned with workload and the unwritten rule that work should be allocated fairly among the wards. The nurse in the example below was concerned because this use of resources would mean that some staff would have a greater workload than others. She used her influence in an attempt to ensure a more equitable distribution of work among the nurses (even though this was initially rationalised as the appropriate use of resources in the interests of the patient).

> *"...and one of our nurses said `well why isn't he going to the assessment unit?` There were actually no patients on the assessment unit and the doctor said `well I think it's gotta stay overnight`. And she said `how do you know by the phone call? Wouldn't it be better to go to the assessment unit, be assessed and if our staff nurse on there thinks it has gotta stay overnight then we'll transfer` because [ward name] has already got x amount of patients and there were staff over there that hadn't got any. And in the end the nurse phoned the ward and said `I'm gonna send this patient round to you, is that alright? `"*

The following section deals with issues of role.

3.12 Issues of role.

Role issues encompass two distinct positions. The first is the fact that junior nurses in particular were unsure about their position and role in the discharge planning process. The second is that more experienced nurses were more likely to call into question the role of others in this same process. Junior staff were unsure who to refer patients to (D Grades, written responses, I3a, 475-501). This is examined further (below) where lack of knowledge is caused in part by senior nurses spending long periods away from the bedside.

> *"I don't get myself involved with bed-baths in the morning. I will give care, bowls out...but I'll never undertake a heavy bed bath because I'm conscious of the fact that as soon as I start it you'll get an interruption...somebody will come and see you, there's a problem, there's another ward round. That's not fair to interrupt a patient so I consciously don't do that but I'm missing out because I enjoy it nut also the patient should demand an experienced nurse to do it. You can train monkeys to wash a patient but what's important is you should be looking for anxiety, checking their anxieties for discharge, their pressure areas, their nutritional status..." (I6A).*

The same nurse commented:

> *"...I think the role has changed considerably really, It sometimes worries me that a lot of people may pay a lot more attention to audits, to results on paper...I certainly think the way the nurse is trained is different...when I trained there was more emphasis on practicalities. Now they give...and I1m not knocking it, its essential that you have a good theoretical basis but I think you need to be able to transport that into a good practical skill and I think part of the problem is we're not able to do that now because of the quick turnover...I sometimes worry now about the emphasis on complaints, they make a difference to how nurses approach patients and how they deal with patients...relatives and patients are more empowered to complain now...I don't think there's enough emphasis placed on communication with relatives and with patients...The role, certainly of the senior grades has changed. G grades, when I first qualified, were out on the wards all of the time you know, management decisions were not taken by them...part of my day is spent trying to recruit, retain, encourage and improve the skills of nurses. And yet you're taking your most qualified, most experienced nurses away from the clinical area. They were out on the ward ten, fifteen years ago" (I6A).*

Nurses perceive that, although their role is expanding (I9A), it is not always for the benefit of patients. Nurses feel that the basics of the role are being either forgotten or being delegated to staff groups who are equally unwilling to accept the roles. One nurse in particular commented that HCAs are now unwilling to provide basic nursing care such as performing observations or giving bed baths, preferring instead to remove drains. There was a feeling that some nurses would accept the extended role because it seemed more dynamic (I9A) but this may be inherent in all nurses since one nurse said "I'm here as an acute nurse, not to sort out who's looking after the cats and dogs at home and things like that" (I3A, 93-95). There are also misapprehensions concerning the complexity of the role of the discharge planners. A staff nurse commented "...they have like eight hours to look at somebody's discharge or two people's discharge, whereas I have eight hours to sort sixteen people out, some for theatre some for home" (I3A, 509-512). The same concept of role as related to labour was voiced again. Nurses seemed to feel that, whatever the role, one should carry out labour appropriate to that role. Of the specialist nurses, one nurse commented:

"No, not at all because I don't think they do anything. I've had a breast care specialist nurse come up to see a patient, come out from behind the curtains (they're nurses)...and say `the dressing needs changing, its just a little bit loose`. Now I'm like shit up to me eyeballs but I'm dealing with something, I'm trying to answer the phone...and I said `well can you change it?` Looks at me as if to say `f***ing hell`...you can tell she wants to wear a nurses` uniform. The others don't, they want to wear suits..." (I9A, 939, 941-951).

3.13 Doctors and the discharge planning process.

Throughout the period of data collection at Trust A it was perceived by staff that doctors hinder the discharge process or are indifferent to it. It should be noted that no information was provided by doctors themselves so these conclusions remain biased. Nonetheless, there are practices originating from the medical staff, which contribute to problems encountered in attempting to discharge patients. From the point of admission their influence is obviously detectable though not always positive. Staff note that problems arise at weekends when inappropriate admission numbers rise because junior medical staff decide to admit patients rather than discharging them, a combination of inexperience and perceived lack of accessibility to senior colleagues (I3A, 780-783). Problems also arise, however, because of consultant idiosyncrasies – "Care pathway system…is there hopefully to reduce the stay of patients in hospital, to get rid of the consultant preferences. Some like to keep them in five days, some like to keep them in ten…" (I1A, 578-580).

Another criticism is that Senior House Officers (SHOs) are not discharging patients. The meaning of this is unclear but if its import concerned weekends when part of the problem may lie in the fact that people are not routinely discharged at weekends anyway because of the problems accessing specialist services and equipment. If this is the case then it seems rather unfair to blame the medical profession for problems that may be related more to inflexible service provision.

As an indication of the diverse views held concerning medical staff, it is also asserted that they discharge patients too quickly. This is particularly the case with community staff who claim that communication is often lacking before discharge. They particularly dislike the "Friday afternoon clearout" because they are often

unaware that patients are going to be discharged and do not find out until Monday. This means, once again, that the patient is thrown back upon informal support networks. Thus, two branches of the nursing profession (acute and community) lambaste doctors for diametrically opposite reasons. The consequences are that doctors discharge immediately before the weekend to ensure that beds are available for the new patients arriving over the weekend (or elective patients on Monday) and community staff may be unable to respond to this because of inflexible shift patterns.

Other criticisms are not so easily dismissed. Kibbler (1999) notes that significant delays occur when patients are waiting to be reviewed by their consultant prior to discharge. Kibbler seems to imply that this problem is restricted to medical wards but this is not the case. Outliers seem to be at greatest risk because of consultant to consultant referral mechanisms and ward round practices. A staff nurse commenting on the bed situation said:

> *"They need `em so the doctors have got to go round and look at people because some patients, medical patients, aren't reviewed on our ward. Three days one lady's waited to see a doctor. The team's been bleeped but if they're not doing a ward round on that day they don't see them unless they really need to like they're poorly" (**I3A**, 687-690).*

Further, the same nurse stated: "well it took a week and a half to refer her to the medical doctors; medical doctors just keep saying `continue` and we do nothing apart from give her pills" (I3A, 725-726). Also, doctors were perceived as not acting on referrals quickly enough and that in-fighting between doctors occurred especially if patients were inappropriately placed on certain wards:

> *"...and when they're over their acute phase, that's when the trouble starts...Once the doctors feel that they've done their bit...that's when the conflict starts. They want to get their next lot of patients in...The system of you have to refer them to the medics rehab team who have to come down and say whether this patient's ready to be transferred on, you get another conflict there" (I1A, 570-577).*

Finally, there were instances where the doctors` frustration concerning bed state spilled into open conflict both with social workers and the discharge planners. In one instance a registrar instructed staff to discharge a patient but the discharge

3.14 Lack of knowledge.

A sound knowledge base was seen as crucial in the maintenance of acceptable standards of practice but that opportunities to acquire the relevant knowledge were hampered by time constraints, lack of study opportunities (I6A, 484-494) and the deskilling which was felt to occur among general ward staff with the advent of the specialist nursing teams. The perception was that their teaching role was not being fulfilled in order to prevent deskilling. A manager said:

> *"I don't think they're taking on their teaching role as they should have done. I think a specialist nurse... their main role should be teaching. They have got that wealth of knowledge and that extra knowledge to...your ward nurse...and they should be passing that on so that when somebody does come in on a Sunday with a stoma they get the same care that they would do on a Monday at nine o'clock in the morning" (**I2A**, 123-128).*

Learning seemed to take place whilst caring and one nurse claimed that learning occurred "through trial and error, it's admitting in the past that I've probably made mistakes..." (I5A, 133-136). The practical components of lack of educational support in the clinical area were emphasised by one nurse who commented:

> *"I would also like to improve it [the discharge planning process] by teaching. I think sometimes the importance of early discharge planning isn't apparent. Sometimes I think that especially junior nurses do an admission sheet parrot fashion rather than thinking of the implications behind what we're asking. We're asking `Do you live in a house with stairs? ` because we're not interested in whether they've got nice carpet on the stairs or whatever, we're interested because potentially that could be a problem. And obviously we need to identify that and sometimes I think that nurses don't really fully understand the implications of the importance of a good assessment. And then even if they do answer it, the importance of acting on the information that they got..." (I6A).*

The importance of a proactive ward manager who took education seriously was identified as crucial in this regard. Some staff were trying to or had developed resource rooms in which some degree of protected learning was possible, whilst others had instituted an informal lecture system. One nurse commented that the

planner felt that it was unsafe to do so immediately. The registrar then called the discharge planner to theatre and told her in no uncertain terms to discharge the patient. A nurse manager became involved and the patient remained in hospital until more propitious circumstances prevailed. Another incident involving conflict between medical staff and discharge staff was recounted by a staff nurse.

> *"This particular patient was, from the medical view, quite fit to go home but he would have bouts of confusion...he'd be a little bit irrational at times. And so...the doctors`d come to see him one instant and he'd be fine and then the discharge planner would come and he'd be a little bit vague. So she'd say `he's not going I'm not happy about this` and so I'd say `but the doctor says he'd gotta go`...And she'd got his discharge cancelled on a couple of occasions which I didn't necessarily disagree with. But then I was the one who had to stand there and explain why he hadn't gone home again and then the doctors would say to me `what the bloody hell's it got to do with the discharge planner?` It got quite nasty" **(IIA, 458-468).***

On one occasion, after completing their ward rounds, two consultants complained bitterly about the number of delayed discharges and the role of social services to the ward staff. These incidents reveal that conflict is generated when doctors feel that patients are inappropriately placed in the acute setting and call other individuals to account for their failure to move individuals on. It is felt that doctors have a lot of "clout" and they are, therefore, entitled to request discharges at a given time whether or not other members of staff feel that these expectations are reasonable. In conflicts between medical staff and other specialists the nurse is often caught in the middle. Discharge planners appeal to nursing staff as fellow nurses in an attempt to obtain a desired outcome. Doctors, however, appeal to nurses from within models of a traditional hierarchy in which nurses are supposed to respect the doctor's authority and the doctor in turn recognises the nurse's ownership of the ward. Newer disciplines find it difficult to enter what are seen as tightly demarcated areas with the monopoly of control resting with the two oldest professions.

opportunities to learn diminished the further one moved away from one's days as a student.

3.15 Relationships.

This section comprises the views of those staff members who are involved in the discharge planning process of the relationships between those same members of staff. This section also includes service users. Doctors were perceived by nurses as being at the top of the traditional hierarchy but this could create tension. One nurse commented: "maybe the doctor who, really, at the end of the day has got the final say, should have just…sorted it" (I1A, 557-559) and "I tend to agree more with the discharge planners than the medical staff, but the medical staff…have got more clout here than we have and it does create a little bit of tension" (I1A, 491-493).

One criticism levelled at the Discharge Planning Service was that some of its members were seen as too idealistic. Nursing staff who were interviewed claimed that they would "look into every nook and cranny and try to overcome everything…" (**I3A**, 354-355). Another nurse commented that there was a limit to the degree of advocacy that could be reasonably expected of healthcare staff and commented that it is impossible to attempt to cure all problems before discharge, especially certain confusional states (**I1A**, 452-453, 472-477). Nurses also felt that they sometimes felt themselves trapped between the conflicting philosophies of medicine and discharge planning. Doctors would look to treat the immediate presenting problem but had a very narrow view of medical fitness, confining themselves to markers such as the patients' ability to mobilise, open their bowels and eat and drink. Once all these parameters were satisfied, medical staff regarded their patients as well enough to leave hospital. Thus, "on the one side you've got the medical side who are badgering us about getting patients out, getting the beds empty. And to some extent the bed managers are too but they're relying on the doctors to discharge people" (I1A, 480-482) "and sometimes we're caught in the middle of that because the doctors are harassing us and saying `I'm going to phone the discharge planners myself to find out what the bloody hell they're playing at because this lady's been medically fit for a week or two weeks`" (I1A, 483-489).

Discharge planners, however, viewed medical fitness as arriving at a situation of "social preparedness" (as one nurse phrased it), "And then the discharge planners are saying they`re not quite ready to go yet…I'm not happy for that patient to go home! (I1A, 489-492, 483-489). Thus, situations commonly arose in which nurses were caught in the middle. "I felt… nurses…were being pulled between two sides" (I1A, 480-481), "it was unfair that I was being used in the middle of these two parts of the profession. They were using me to pass messages back on to the other one to say `pull your bloody finger out` …I resented that bit. Whereas they could have just got together and just sorted it out amongst the two of them" (I1A, 552-557).

On the whole, however, the nurses commented that they had a good relationship with the specialist nurses despite the fact that conflict on occasions was seen as inevitable (I3A, 311-315). This was felt to be because the specialist nurses and discharge planners were "nurse-based" and also because the specialist nurses were more visible and more accessible (I1A, 230-234). Relationships with the social workers were felt to be poor because of poor visibility (I3A, 323-324, 332-334). Some nurses and managers commented on the fact that there was always room for improvement in the area of personal relationships and part of the problem remained the desire to always protect one's own area (I6A). It was recognised, however, that it was important to empathise with staff from other departments in order to address these shortcomings. "I recognise that they're in the same boat as me, that they're understaffed…that they're overworked" (I6A. I2A, 77-85, 90, 94-97).

One recurring theme was that the quality of relationships enjoyed by staff was mediated by the level of experience each staff member has. A nurse, commenting on the relationship between doctors and nurses, claimed that "its generally good. Certainly the links between senior nurses and senior doctors is good and then everybody else tends to take the lead from that…" (I6A). This was reinforced by the same nurse claiming that consultants will help nurses to try and improve the patient experience by, in this case, trying to provide information for patients undergoing a cholecystectomy. The nurse also reiterated how important it was for the nurse to act as the patients` advocate but that this entailed standing up to the consultant.

> *"The doctor in question didn't like the nurse, went on a ward round together and just took no notice of anything the nurse had got to say. Did it in a manner that was probably not right as well, did it in the middle of a bay, showed the nurse up, upset the nurse and the consequences were I had to sort it out and just because of their bad communication. But it stemmed from the lack of respect" (I6A).*

The relationship between nurses and the people in their care veered between open empathy, mistrust and guarded hostility. Although all nurses recognised that delayed discharges were rarely the fault of the individual patient, they recognised that some patients and relatives played the system and that they themselves blamed the patient on occasions. Sentiments ranged, therefore, from "it's the patient that actually suffers because they're fed up" (I3A, 244-245) and needing to do your best whether the patient is a delayed discharge or not (I5A, 244-252, 256-261) to "You don't get that with all patients, but a lot of patients…take on the sick role, they still demand all the attention. It could be two weeks after their operation and they're saying that the nurses haven't come anywhere near me today and you think that's because we don't need to, not really" (I1A, 633-638). Elaborating upon this, the nurse commented:

> *"I feel that a lot of the times when you've had a patient who's been quite ill and needed a lot of care, that they can't let go of that. They tend to be the patients who are more demanding and then you find yourself sometimes getting a bit short with them, having to say to them `when you were really ill I had to be there for you, well its somebody else's turn now`" (I1A, 629-633, 638-642. I3A, 846-852).*

Sustaining meaningful relationships with patients was seen as an important part of the nursing role but such relationships were highly dependent on workload and speciality. Staff on longer stay wards have the opportunity to establish intimate therapeutic relationships with their patients and were more likely to tire of those relationships, especially when faced by the demands of the organisation in respect of throughput. Those staff on short-stay wards found that the quick turnover of patients militated against anything but the briefest relationship, so much so that delayed patients were sometimes welcomed (I9A, 1158-1167). One nurse commented "I think we've got one now who could have gone home today but he

doesn't want to. But he`s not a bed-blocker as such. I think we're just being a bit nice (even though he was horrible to me the other day…" (I9A).

Nurses also commented upon verbal abuse they have experienced at the hands of patients, aggressiveness and selfishness of patients, the need to feel valued and respected and the standard of modern nursing students. It seemed that even quite junior nurses wanted to return to a utopian age where nurses were considered saintly, where they could enjoy their role without abuse at the hands of relatives and patients and be thanked rather than complained about.

3.16 The discharge lounge.

Developed to both ease pressure on acute beds and provide nursing care in a more appropriate if highly temporary setting, the discharge lounge elicited mixed, though never wholly positive responses from many of the participants. It was recognised that it is "very much part of their remit is to get as many patients out of beds and into the discharge lounge as possible to free up beds for admissions" but that "if you're not assertive, it can make them hurried and unsafe" (I7A, 598-601). A charge nurse added that "it doesn't allow you to

> *"...work in a holistic manner...you've been looking after a patient from admission to discharge but they want to drag them out of bed and stick [th]em in the discharge lounge. Whereas you want to make sure that all the `t`s are crossed and all the `i`s are dotted before you send them. And you still feel responsible even though a patient goes down there and they've got qualified staff..." (I5A. I7A, 441-445).*

Not all wards have the luxury, however, of sending patients down to the discharge lounge or not (I7A, 436-437, 440). Those ward staff whose patient turnover is highest have to use this facility although patients who are regular visitors and require no medication are discharged straight from the ward although some regular patients do object if they have to transfer to the discharge lounge having been discharged from the ward previously (I7A, 510-514). Information giving appears crucial in this regard. Patients are told wherever possible that the transfer to the discharge lounge is an expected part of their journey through the system (I7A, 463470, 474-478, 482-489). There have been occasions, however, where staff have

been seen as being too aggressive towards ward managers in their attempts to get people to the discharge lounge immediately (I7A, 559-575) and there was also a tacit admission that perhaps some patients are transferred to the discharge lounge before nurses think they are ready (17A, 603-605, 609-612).

3.17 Social Workers and Nurses in the discharge planning process.

There were six adult teams serving Trust A but this has since been reorganised. The hospital social work team has been moved into the community, amalgamated with the four locality teams, leaving five teams one of which is based at a neighbouring acute facility. The basing of the team at the neighbouring facility is necessary because of the close geographical ties between the two Trusts and the degree of overlap in referrals and services between the two.

During the two days spent in the hospital social work department of Trust A there were nine social workers on duty, six in the main office and six in the duty office located across the corridor. Three of these personnel were agency staff and one-third of the permanent staff were on sick leave or study leave. It was unanimously agreed that such staffing levels were inadequate. Gould (2001, p.9) reports that councils in London and Birmingham have vacancy rates among social workers of 40% and 26% respectively. Social workers felt that even if the department was at full strength there would still not be enough staff to cope effectively with the current workload. One person commented "we've never had enough staff". Caseloads vary but the average number of cases dealt with by a single social worker is 18, the most being 25. The department currently operates a "central allocation system" in which all new cases are received via the duty social worker and are then allocated. The previous system in which social workers were linked to consultants and specialities resulted in caseloads of approximately 40 at any one time. There is also a fast track social worker who works directly with the Community Liaison Nurse (CLN) in the Accident and Emergency Department (A&E). This is an attempt to try and filter admissions through A&E to prevent unnecessary hospital admission by screening out those persons who require social input only. These individuals may, for example, be admitted to a respite care or rehabilitation bed.

Following discharge from social services, each person is supposed to be reviewed after one month and then six monthly intervals but it was admitted that this is impossible to ensure because of staffing pressures and the subsequent need to try and limit caseloads. Thus, the caseload of a social worker is invariably higher than stated although some persons require less intensive monitoring and support than others. Also, the caseload has the potential to increase rather than decrease or remain static since even those individuals who have been discharged must be reviewed regularly by a member of the locality team in which the person is resident.

Negotiations between hospital and locality teams commonly occur to determine which of the teams should take responsibility for a particular case. If, for example, a client check reveals that a patient is already known to a member of the locality team they will assume responsibility for the case. If there is no previous association between the patient and the social work department then the hospital team will undertake the necessary arrangements but the person will need to be allocated a social worker from the locality in which he or she is resident. This should occur ideally before discharge. Boundary disputes concerning allocation and responsibility do arise and the final arbiter in these cases is the Principal Social Worker.

According to the Social Services Profiles Information document, the average time taken in 1998-1999 between referral and the start of an assessment was 45 days. This is an increase of four days on the previous year (p.8). Departments in Trust A in the period 1997-1999 saw a decline in the number of simple assessments undertaken. In the same period the number of straightforward assessments rose by one percent. The number of complex assessments, however, rose by 13%. Assessments undertaken by all members of the health care teams involved in discharge planning within Trust A have increased dramatically during the same period. Simple assessments have increased by 21%, straightforward assessments have increased by eight percent and complex assessments have increased by 58%. The number of completed assessments in Trust A has increased by 100%.

Because of this increased pressure, the social work department of Trust A seems to have become less responsive. One of the first casualties of increased demand

would appear to be an effective duty office. When referrals are first made to the department (normally by telephone) a receptionist takes the message and passes it to a duty social worker. Previously, it was the main task of the duty social workers to take new referrals, liaise with staff and deal with queries from the public. Now, however, because of increased demand duty social workers also have a caseload. A number of social workers felt very strongly that this should not have happened. As a result of this, communication is directly impeded. In one incident a phone call was passed to the social work team from the duty office some two and a half hours after they had received it. It concerned a lady who had fallen at home.

The main problem (highlighted by Kibbler above) is the time it takes for assessments to be initiated. Kibbler (1999) found that it took approximately 11 days for an assessment to commence; if the time it takes to complete an assessment is added to this, the time between referral of a person requiring complex care and the completion of a pre-discharge care plan averages 31 days. Table 3.8 (below) gives the time taken to complete assessments.

Table: 3.8. Time taken to Complete Social Services Assessments

(source Annual Report of Social Services Activity, 1998-1999, p.98)

	Standard.	**1997/98.**	**1998/99.**	Difference.
Simple.	7 days.	28 days.	16 days.	-12 days.
Straightforward.	21 days.	32 days.	16 days.	-16 days.
Complex.	28 days.	28 days.	20 days.	-8 days.

In one incident reported by a staff nurse it was claimed that a family were so "fed up of waiting" they would fund the placement of their relative themselves. The timing of social work assessments results from the attempt to prioritise their workload under extreme pressure. They do this by assessing patients who have a known discharge date. If a referral is submitted by nursing staff, social workers will ask for a discharge date. If the discharge date is unknown the social workers will note the referral and ask the nursing staff to alert them as soon as a discharge date is known. One ward manager commented that "nurses plan for discharge from day one but social workers will not begin dealing with patients until they are

medically fit even when it was obvious from the beginning that their input would be required".

Nurses have highlighted other points of conflict with the social work department in Trust A. Ward staff complain that messages are taken and not responded to, that it is difficult to speak to a relevant social worker over the telephone and that information is transmitted to social workers by the nursing team and then lost. They also complain that social workers were reluctant to visit the wards and that when they did they did not always document their visit or the results in the nursing/medical notes. One social worker admitted that information was not always recorded for the benefit of the nursing and medical staff, although the variable quality of record keeping among many health care staff has been a perennial problem within the NHS as a whole.

Because of the above factors, many nurses perceive social workers to be ineffective. The comments provided from an NHS consultation document are revealing in that social workers were believed to cause "bed blockers". One ward manager commented of a patient that they were "bound to be a delayed discharge because it's a social work referral". Another ward manager (presenting a rather more balanced view) commented that "there are often problems with the social work department. The individual social workers are excellent and I have a good working relationship with them, but unfortunately there are not enough of them and / or lack of funds". Given the apparently low esteem in which the social worker role is held, comments mirrored this in being almost entirely negative. One staff nurse commented that being involved with the social work department was "…like hitting a brick wall". Another commented that "if you refer anything to social services it just gets lost in a black hole".

Social workers readily understood the workload and lack of time in the daily routine of nurses. Telling criticisms were, however, made of the nursing service. Those criticisms levelled by members of the two professions regarding the other are strikingly similar. Regarding referral between members of the two disciplines, social workers claimed that few referrals were received which were inappropriate in terms of need but that nursing staff would often refer while medical intervention

was still ongoing, that the timing of the referral was inappropriate. Nursing staff counter this by claiming that because the allocation and assessment process takes so long they are forced to refer immediately. Because of this nurses "cheat" by giving an estimated discharge date in order to speed up the process. One sister claimed a lady was for discharge on a Wednesday and then added "well, that's what I told the social worker". In an employee newssheet (undated) the point is made that for the Trust discharge planning is an issue of "central strategic concern". The point is also made that the costs of mistakes in this field can be great. Finally, the author asserts that "patients who are awaiting needs assessment need early referrals to social workers…to start the ball rolling". It would seem that early referrals are being made but not acted upon.

Social workers also claim that nurses do not pass on information at handover. This has resulted in repeated requests for social work intervention, which have, in fact, already been acted upon. During the time spent in this department a phone call was received (from one of the ward nurses) requesting intervention. It transpired that the social worker had already visited twice and the patient had declined all offers of help. It is difficult to trace the cause of this incident since both nurses and social workers failed to document information. It would seem, however, that if an intervention or plan is not documented in the notes then there is an increased likelihood that it will not be handed over to nurses on succeeding shifts. Poor communication and duplication of requests would then seem to be multifactorial.

All social workers felt that communication between their department and the wards was poor. Grievances included the fact that nurses do not inform the social work team of patient discharges. This was seen as not only a common courtesy but also vital in that all parties must be aware of the arrangements made before a patient is discharged. In the case of the social work team this was particularly resonant because care plans and care contracts must accompany the patient. This means that social workers must spend a significant amount of time trying to trace patients so that the relevant paperwork can be sent, whilst on the wards there were numerous occasions when the ward received phone calls informing the ward of an assessment date. The ward staff then informed the social worker that the patient had been discharged. In some cases the patient had been discharged for a week before the

social work team became aware of the fact. Given the variable transmission of doctors` letters this means that people are discharged from hospital without key personnel being aware, the informal network of carers must be relied on to provide services rather than being aided by a member of the NHS. It was asserted that all social workers have had the experience of telephoning a family to ask how the patient is progressing, only to be informed of the patient's death by the family.

Two further incidents highlighted the lack of communication between the two disciplines. The first concerned a lady who was transferred to a residential home. After the transfer was completed, the social worker claimed that the home staff were not ready to receive the patient. The second incident was an example of non-communication between members of the social work department. The patient was still on the ward awaiting social worker allocation. The relatives received a phone call from a social worker asking how the person had settled in at the nursing home. This caused a good deal of upset among the other members of the family. Since this person was already having home care it must be assumed that the lack of communication occurred between the hospital and the locality teams, or that the nursing staff failed to notify the community staff of the person's admission to hospital. Their GP is supposed to be informed of their admission also. The authors of the document "Of Primary Concern" (personal correspondence) suggest, however, that GPs are not aware that 20% of patients have been admitted. These missed referrals are, according to this document, a major cause of delayed discharges and has led the staff of Trust A to appoint a Community Liaison Nurse (CLN) to attempt to reduce the problem.

3.18 Communication within the discharge planning process.

In the previous section the concept of gate keeping was examined. It was found that there were a number of strategies employed by health care professionals which, whilst attempting to husband resources, had the effect of categorising others, diminishing contact between health professionals and fostering negative perceptions. Communication is directly affected by such processes and this must affect arrangements for discharge. This assertion will be examined in this section.

How do members of this Trust communicate and what effect does this have on the care individuals receive before and after discharge?

Nurses and other staff feel that good communication is an extremely important part of the discharge planning process. There are, however, a number of disparate elements, which affect the process of communication but because of the nebulousness of the concept it is difficult to delineate those constituent elements. Miscommunication can arise as a consequence of a single typographical error or can embrace whole systems. An example of the first is a message taken from the Core Brief for October/November 1999. It states that:

> *"There is a leaflet entitled `Guidance for the Bereaved` which is located on all wards and on some departments. One of the two telephone numbers is incorrect – [number] is for Lucas Aerospace who are annoyed that they keep receiving calls from bereaved relatives and friends..."*

This seems to be an extreme view since other respondents have claimed that a very short time after the phone call is made to the DPS a sister will visit the ward (I1A, 260-265). Some duplication was evident. A staff nurse commented that the discharge planners should be based on individual wards because one discharge planner attended a multidisciplinary team meeting and another discharge planner arrived on the ward shortly afterwards requesting the same information. The same problem was noted by another nurse who commented that bed managers ask for information whilst other people "who's role isn't clear" (I5A, 333-339) ask for the same information five minutes later. A discharge planner based in the community claimed that it was problematic on occasions having to liaise with a large number of specialist nurses.

Certain data collected suggest that the good working relationship between hospital and community staff, which is a prerequisite to effective discharge planning, is in need of improvement in some cases. One of the community-based discharge coordinators was scathing in her remarks about the acute sector. She claimed that nurses were always "sitting around" and that the predominant ethos in hospital is one of complacency and a feeling that "it`s not my problem". This was reinforced

by the same participant who claimed that members of this practice approached a ward at Trust A with a view to developing a pre-assessment protocol which would mean the transmission of information between the ward and community facilities throughout a patient episode. It involved pre-assessment in the community and pre-assessment in the hospital. The advantages of this are obvious, trends could be established and the hospital staff would have a better understanding of the person's home circumstances and functional ability in normal surroundings. According to the participant, the ward staff were defensive and almost hostile in their rejection of this proposal. This had interesting sequelae. I approached the staff on this ward to ask if I could carry out data collection but was politely informed that complex discharges do not occur on this ward and that my time would be better spent elsewhere.

As an example of just how easy it is to form erroneous perceptions, the participant began discussing ophthalmic patients and I made the comment that these people did not require complex post-discharge care. The community nurse pointed out that they cannot see, lift (so help would need to be provided with ADLs such as shopping, laundry, heavy housework), they also cannot work and many have dependent spouses or relatives. They may, therefore, require sustained and complex input.

The primary method of communication within and between health care facilities remains the written document and such documents provided many examples of the defensive posture outlined above. The way in which nurses viewed documentation was apparent in some of the shorter interviews. Nurses seem to use notes in order to describe a series of events and set them down as an almost immutable and irrefutable record of events. Descriptions of conflict with other health care professionals were followed by such emphatic exclamations as "and it's documented". This is interesting given Silverman's (1993) comment that documentary evidence supplants and supersedes the reality it was supposed to represent. It is as if the notes are being used to construct a version of reality, which reinforces the negative perceptions held of other groups. This is in contrast to the manager interviewed (I2A) who emphasised the need to understand the roles of others, a capacity which may develop when experience and opportunity allow

nurses to escape the narrow geographical confines of their ward or department. Within Trust A, a merger between the Discharge Planning Service and the Social Services Department was envisaged. One discharge planner was against any form of amalgamation since the service provided would be impaired and the Discharge Planning Service would lose its identity. Thus, there is some accuracy in the assertion that it is possible to retain individual roles whilst strengthening ties between them. One community nurse claimed that social workers and nurses would routinely perform elements of each other's role if the other was not available.

On admission to hospital, at the very time when discharge planning is supposed to begin, communication between acute and secondary care staff is poor. Nurses in Accident and Emergency are supposed to inform the relevant practice when one of their patients is admitted so that assessment by the community nurses can begin immediately but this too does not happen with regularity. At this time Trust A has appointed a Community Liaison Nurse (CLN) to investigate the problem. This may lead to an improvement in the situation. Initial assessment in the Accident and Emergency Department was also thought to be poor. Ward based nurses frequently complain that, despite the introduction of new documentation, information received is sparse. Studies of patient notes support this view.

In a number of instances a professional clinical service involvement was not documented, the relevant section was left blank. Even allowing for the tremendous time and workload pressures the department staff are under there seems little excuse for the fact that documentation is of a uniformly low standard. This means that, contrary to the definitions given by all nurses, discharge planning does not start on admission if the point of admission is taken to be the Accident and Emergency Department. The low standard of initial documentation increases the likelihood of confusion and the duplication or omission of services and those patients requiring complex assessment who are not referred directly from Accident and Emergency constitute a major source of delayed discharge. Problems within this department must be addressed if the discharge planning process is to function effectively as a system.

Communication in these areas is by means of joint documentation in which all disciplines write in the same set of notes. There are four problems associated with this form of record keeping. They are the use of abbreviations, record entry, illegibility and content. One particular area mentioned was the use of acknowledgement slips which can be left by social workers to alert staff to the fact that they have seen a patient without writing in the notes but these are used rarely, one experienced nurse commenting that she had only ever seen one. The use of abbreviations would appear to vary between occupational groups as a function of the nature of the work. A case note audit was carried out at Trust A (1999). The audit tool included the statement "all abbreviations are kept to a minimum". Most of the notes contained some abbreviations and indeed Trust A has circulated a list of allowed abbreviations. Some of the abbreviations, however, were impossible to determine. For example, the following was found in one set of notes: "Patient doesn't look so well today→quite pale. SOBOE. Sit i/c st- Mob with ZF+supervision only. Not lifting ® l.l well. Slow c SOBOE. Rx 1+2 P cont as able". Other abbreviations included "SALTS" (Speech and Language Therapy Service), "SOBAR" (shortness of breath at rest) and "TITS" (trimming of inferior turbinates). Regarding the content of records, one nurse commented that nurses were not taught to discriminate. Everything was written in the notes and this must produce much irrelevant ("background") information. The nurse claimed that many nurses remained afraid to use their judgement and were afraid of the possibility of litigation. The medical case note audit revealed that from 26 sets of notes reviewed 25 (96%) contained minimum use of abbreviations whilst only 1 (4%) contained excessive abbreviations. The audit sample was extremely small and the word "minimum" is not defined. Observations from this study indicate that the use of abbreviations at more than a minimum level occurs more frequently than this audit suggests.

Fax machines are used within Trust A but not all wards have easy access to them (unlike Trust B where there is one on each ward). Many forms need to be faxed to community agencies and the nurses must leave the wards to do this. If the ward is busy, however, professional considerations of patient safety and comfort mean that the task of faxing forms gets passed on to the next shift. One nurse commented:

*"...we have to get it faxed to the [social work] office and that's a mission in itself. Cos we have to find somebody then with a fax machine who'll fax it for us or go off and fax it ourselves which, if there are only two trained staff on, that's the least of your priorities to be faxing forms. So you pass it on to the next shift and that's how it gets delayed. It gets passed on and passed on" (**I3A**, 73-76).*

The main medium of communication remains the telephone but this method is unreliable in isolation. Nurses must spend a significant part of their working day on the telephone and reliance on this medium of communication increases the chances of information either being forgotten, messages mislaid or not transmitted if it is impossible to reach a particular individual.

Another problematic area is the nursing handover. Social workers claim that nurses do not always hand over information correctly to the next shift and this results in either repeated communications or absent communication. One nurse admitted that information about discharge arrangements is forgotten because its priority is low when the patient is admitted and then information is not passed on between shifts. He said:

*"There are still times when we're not sure how far down the line we're getting with a discharge and on a ward round the doctors`ll say `what's happening with so-and-so?` and we`ll have to make a conscious effort to go and find out exactly how far. The communication breaks down a lot of times with the nurses...because in report it might not be passed on to the next shift any advancement that's been made in the discharge. The report will concentrate more on the patient's condition. So it might be mentioned for the next couple of shifts after, but then not be mentioned for a while and I might come back after a few days off but they wouldn't necessarily mention that as a priority. They wouldn't necessarily say to me `we've got this far with the discharge. They might say they've referred to the discharge planner say in the first couple of days because that's just to say we've done our bit. But then unless you consciously make an effort to go and read the notes or chase them up you might not be one hundred percent sure exactly how far we've got" (**1**, 262-275).*

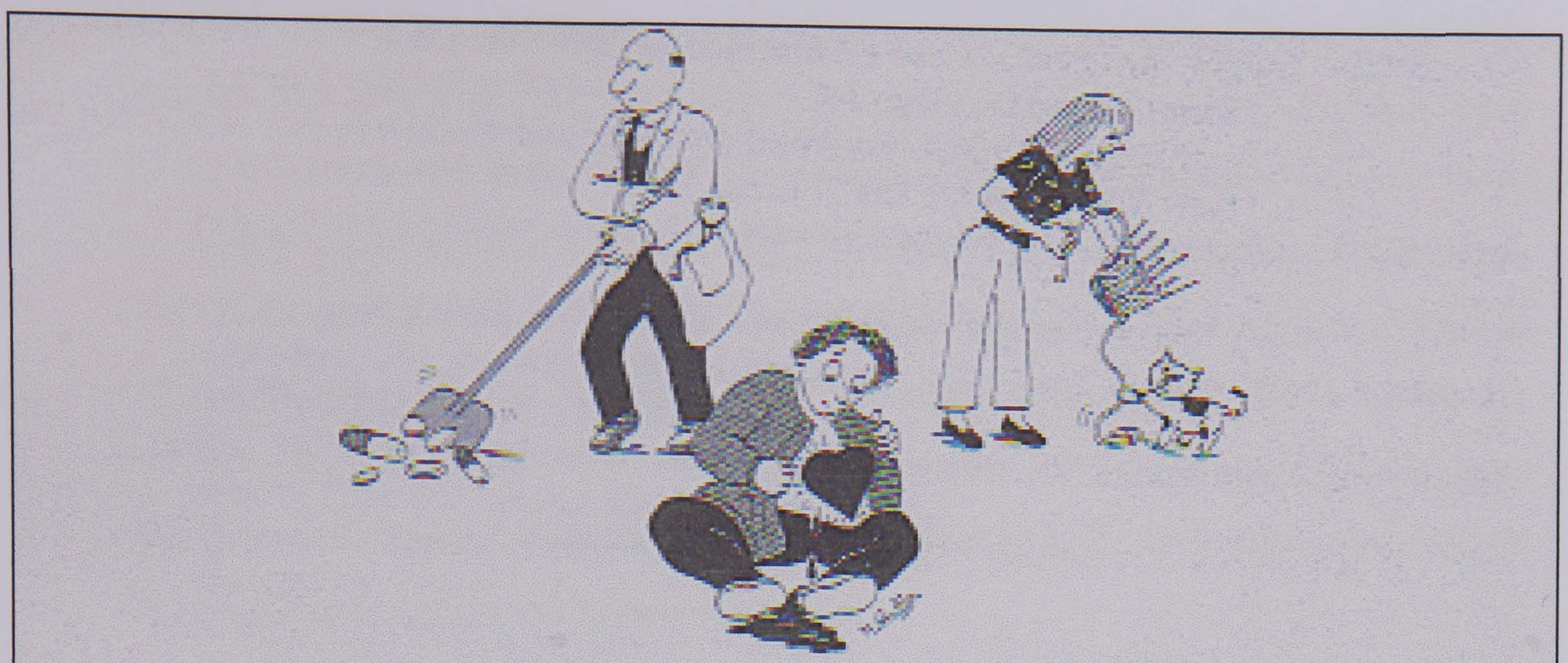
Communication has become problematic because of the changing role of the nurse in the discharge planning process. Previously, nurses were the central point of information exchange but no longer. Because there are many more disciplines involved in the discharge planning process, nurses must change the way in which

they interact with other professionals. Rather than having information readily available, the nurse must make a "conscious effort" to find the information. In a survey commissioned by Trust A 52% of staff felt that communication with other areas was good but only one third of respondents felt that other departments appreciated their problems.

3.19 Summary

In this chapter, it was noted how various processes serve to exacerbate demand for hospital beds. In particular, it was noted how emergency admissions and the practice of outlying patients creates pressures on elective surgical work, rehabilitation places and social work departments. This, in turn, means that service delivery becomes fragmented as more specialist nurse roles are created in an attempt to expedite discharges and sustain patients safely in the community. Specialist nurse posts tend towards an increase in role confusion because of deskilling, idiosyncratic referral mechanisms and working patterns and an unwillingness or inability to disseminate knowledge. Also, the targeting of specific client groups may mean that others are left in a vulnerable position.

The amount of bureaucracy has also increased leading to increased likelihood of error as senior nurses are unable to pass on knowledge to junior colleagues. Furthermore, various occupational groups, in an attempt to reduce workloads, devise ways to reduce the number of appropriate referrals by narrowing eligibility criteria. All this means that, as roles expand, confusion increases which leads to detrimental effects on communication processes leading to increased occurrence of poorly arranged discharge, early readmission and consequent bed shortages. In the next chapter, discharge arrangements at Trust B will be examined to see if similar impediments to seamless care operate there.



... with doctors labelled as 'pill pushers',

Social workers as 'bleeding hearts', and occupational

therapists as 'basket weavers'.

Chapter four: Findings from Phase II of the study.

In describing Trust B and the various teams which discharge adults across the primary/secondary health care interface the same manner of presentation will be used as the discussion of findings from Phase I of the study (and discussed in chapter three).

The information within the two sections devoted to findings from data collection has been matched as closely as possible and provides sufficient context for the reader to both obtain some idea of the catchment areas and the health care establishments themselves, as well as allowing general trends, similarities and differences to be extrapolated from the data provided here.

The second phase of the study was carried out at a second acute facility in the Midlands (Trust B). The Trust buildings occupy four sites comprising two acute centres, an outpatient's facility and an establishment that specialises in general, stroke and orthopaedic rehabilitation. The total number of beds available is

variable depending on the source chosen. The figures given in the Government's Hospital Activity summary, 1999-2000 (http://www.doh.uk/hospitalactivity) indicate that there are 871 beds which are open overnight and 85 day only beds giving a total of 956 beds. The West Midlands Hospital Pharmacy web-site gives the total number of beds in March 2001 as being 952, a discrepancy of four beds. The Sunday Times "Good Hospital Guide" (2001) gives the total number of beds as 830. Activity analysis for this Trust reveals the following (given in Table: 4.1 below). The percentage occupancy rate for the year 1999-2000 was 85.3 for those beds open overnight (compared with Trust: A that has 573 beds with a percentage occupancy rate, for the same period, of 84.9).

Table: 4.1. Hospital Activity Analysis of Trust: B (1999-2000).

Category.	Attendees	Total "did not attend".
Outpatient attendances	292,991	
Ward attendances	14,150	33,364
Accident and Emergency attendances	91,581	
Day care attendances	5,414	
Imaging and radiodiagnostics: total procedures	186,555	

It can be seen that ward staff bear only a small burden compared to other departments. The questions that need to be addressed, therefore, are why do ward staff perceive themselves to be under such pressure and what are the practical consequences of this for the discharge planning process? Answers to these questions will be provided in the discussion that follows. The wards chosen within this Trust and their speciality are given below in Table: 4.2 (below).

Table: 4.2. Wards chosen within Trust: B and their speciality.

Ward.	Speciality.
B1.	Surgical.
B2.	Short-stay surgical.
B3.	Surgical.
B4.	Medical.
B5.	Medical.
B6.	Medical.
B7.	Orthopaedic.

The wards at Trust B were chosen for the following reasons. The inclusion of two

Trusts within the study allowed for data triangulation, ensuring an increase in the validity of the conclusions drawn. In order for this to pertain, however, it was necessary to ensure that the wards chosen at Trust B mirrored those at Trust A in terms of speciality. Like Trust A, medicine, surgery and orthopaedics form the vast majority of the workload of this Trust. Hence, choosing wards at Trust B to mirror those of Trust A allowed more direct comparisons to be made.

No elderly care ward was included because that proportion of patients who are considered to be elderly are dispersed throughout hospital specialities and do not constitute a speciality in their own right and, therefore, do not occupy a specific ward (although there are physicians who specialise in elderly care).

The summary of findings from Trust B are structured in the same manner as those from Trust A insofar as the organisational and operational idiosyncrasies of each Trust make this possible.

4.1 Population structure and its effects on admissions.

The area in which the facility is located is classed as a mixed rural urban area according to figures provided by the Office of National Statistics (ONS) in August 2001. In terms of population characteristics and geographical properties, the borough comprises twenty-four wards with a total population of 311,500 at mid-1998 numbers (ONS 2001). Other information regarding population within the catchment area of Trust: B is also available. The Annual Report of the Director of Public Health (1997, p.1) provides the following information. In 1992, the residential population was 302,019. In 1996 the residential population in the borough was 307,933; this figure excludes persons resident in local authority accommodation such as homes, hospital and hostels. Comparison of these two figures reveals an increase in the residential population of 5,914 persons.

If the residential population was to include people in some form of local authority accommodation other than council tenants then the total 1996 population would be 310,800, giving the total population resident in care homes, hospitals and hostels as 2,867 (0.9%). Adding 0.9% to the mid-1998 figure of 311,500 gives an adjusted

total population of approximately 314,304. Unfortunately it was not possible to obtain more up to date figures than those cited but these figures serve to illustrate general population trends within the catchment area of Trust: B. There will be, according to the ONS, a 32% increase across the district in the number of males aged 65 years and over to 23,934. The number of women across the district who are aged 65 years and over will increase by 14% to 29,833. Finally, the number of persons aged over 75 will increase by 28% to 22,129. Comparable districts include Walsall, Wolverhampton and Trust: A. Both Trusts are seeing an increase in the numbers of elderly persons in all age groups but especially in persons aged 75 years or above. The most marked increase is in the number of women who are aged 85 years or over which is estimated to increase across the catchment area of Trust: B by 35%. The population projections for elderly people in this area are given in (Table: 4.3).

Table: 4.3. Population Prediction Elderly People in catchment area of Trust B (in thousands). Source OPCS 1989

	70 - 74	75 – 79	80 – 84	85+	Total
1991	11.76	9.19	6.02	3.77	30.74
1996	12.69	9.31	6.48	4.63	32.93
Percentage change between 1991 and 1996.	7.9%+	1.3%+	7.6%+	22.8+	7.7%+

Other indicators are housing quality and amenities, the incidence of coronary heart disease (CHD), wage levels and expenditure by Social Services Departments in this area. In 1995 deaths from CHD accounted for 853 residents of which 15% occurred in those under 65 years of age. Deaths from CHD were lower than the West Midlands average but slightly above the national average. They were considerably lower than the rates in Trust: A. Regarding housing, the Director of Public Health 1996 report (p.32) states that:

> "The…Housing Condition Survey 1995 found 5.6% of privately owned homes and 27.8% of privately rented homes to be unfit, usually because of poor cooking/washing facilities, dampness or disrepair. This compares with rates of 20.5% nationally for the private rented sector".

In terms of unemployment, although rates in this area are falling in line with

national trends, 51,900 (42%) of persons currently employed are defined as being low paid in that they are paid less than two-thirds of the national average wage for adults. Concerning Social Service's predicted spending in the borough, the estimated expenditure in 1994-95 on elderly persons will be 15.79 million pounds- some 45% of the total predicted budget.

In that part of the document entitled Community Care Plan, it is recognised that certain sections of the population require help with certain activities of daily living (ADLs) in line with Waters` (1987) findings. Research carried out in the Kidderminster area revealed that of people aged over 75 years "60% need assistance with shopping, 40% need assistance to prepare a meal, 61% need assistance with heavy housework [and] 61% need assistance to cut toe-nails". With this in mind, the Local Authority has instigated a bathing assessment unit (page 29). This unit is still operational although like many other sections of the service its staff are under pressure. Occupational Therapists related that even when a need for assistance is identified in an area of a heavy ADL such as bathing, there is then up to a four year wait for a bath hoist by means of which many people could be assisted to remain in their home without having to make a long journey to the unit. Finally, the report details the numbers of staff (1994 – 1995 figures) currently involved in community care. There are 80 District Nurses, 57 Health Visitors and 21 Sisters specialising in elderly care although it is not clear from the report what their exact role or location is. Since this time of course there has been the advent of the discharge liaison nurse although in the catchment area of Trust: B they are few in number and remain housed in the hospital and not attached to GP practices. Like Trust A, Trust B is currently undergoing significant structural change in order to facilitate the advent of Primary Care Trusts (PCTs).

4.2 Summary.

Figures suggest the population within this borough is relatively impoverished with a significant proportion of persons being elderly, unemployed or low paid. Deaths from coronary heart disease are above the national average and a larger percentage of housing is deemed to be unsafe (almost seven percent more than the national average). The elderly population within the catchment area of Trust B is predicted

to increase and spending on social care is expected to increase to cater for the demands of an elderly population, a large proportion of whom require intensive and sustained help if they are remain safely within the community. All this takes place against a backdrop of limited health care resources. It appears that both Trust A and Trust B suffer many of the same problems regarding the absence of key resources the possession of which enables individuals to resist illness or poverty. The absence of such resources may mean that extra pressure is placed upon acute facilities of Trust B and that, as a consequence, stress and conflict among disciplines arise increasing the likelihood of poor communication. This in turn gives rise to negative perceptions and tightened occupational boundaries as the defensive posture comes to dominate.

In the following section resource allocation in terms of modes of admission to acute beds within the Trust will be examined. Like Trust A the mechanism by which scarce health care resources and the needs of an increasingly dependent population impact upon acute services must be made explicit. Like Trust A the point at which this increasing pressure on the acute sector is most likely to be felt initially is at the point of admission. Hence, admission procedures form the next point of discussion.

4.3 Modes of admission within Trust B.

The modes of admission in the two Trusts are identical. Patients find themselves within the remit of the acute facility when they are admitted as either an emergency or as an elective surgical admission. The mode of admission of emergency patients is slightly different within Trust B compared to Trust A. Trust B has both a Medical Assessment Unit (MAU) and a Medical Assessment Ward (MAW). Trust A (at the time of writing) had only the former although the latter is planned for 2004. As has been argued in the case of Trust A, the decision to admit patients in to the Accident and Emergency Department has consequences for the organisation; all departments are affected sequentially by a backlog in the department. The rationale behind MAUs and MAWs is that pressure would be relieved on the Accident and Emergency Department since patients could be transferred relatively more quickly from that department despite requiring initial assessment there. The staff on the MAU/MAW would then selectively filter the patients, sending them to other wards.

Persons assessed as having medical problems and who were non-GP referrals would be sent to the MAU. Those who were sent to hospital by their GP would, after a speedy assessment in A&E, be sent to the MAW.

This is problematic, however, since whatever name is assigned to a ward, whatever purpose the ward is put to, there are still the same number of beds. Indeed, the Audit Commission (2001) found that the provision of MAU/MAW wards made little difference to the level of service provision in Accident and Emergency. This was corroborated by a staff nurse who claimed that the system did work but during times of peak pressure failed rather than because of lack of beds for people to go to from the Accident and Emergency department. There is also the fact that GPs normally phone the hospital requesting a bed on MAW. If they are told that there is no bed available then they will send them to A&E anyway. It would seem to be the case then that at peak times referred to earlier as "weather pressures", the system breaks down because there are simply not enough beds. Tracing the backlog, one finds again that the number of rehabilitation beds is crucial for the correct and safe transfer of patients from acute to primary care whilst at the same time relieving pressure on all departments including the Accident and Emergency Department.

Some mistakes as a consequence of this pressure were described by a member of staff. She asserted that there were a number of elderly patients who had been transferred to a local nursing home from the Accident and Emergency Department with undiagnosed fractures of the pubic rami. Once the fractures had been discovered the person was taken straight back. Although the exact number was not specified it was at least two. This would seem to illustrate that when departments are under pressure the temptation is to assess patients as being fit and to carry out only a brief assessment. This clearly leads to readmission in some cases. This was not the only time during data collection where the question of poor assessment (whether medical or nursing) was raised. Within Trust B there is a multidisciplinary team whose function it is to track patients out in to the community and to provide services for the first week following discharge or until the community led services take over the responsibility for care. Although this may represent a method of filling the gap that occasionally exists whereby patients are discharged from A&E and are not followed up until their social assessment, care is

needed. The fact that people are still being discharged on occasions with undiagnosed health problems means that the system is far from perfect.

4.4 Bed use within Trust B.

Like Trust A which saw reasonably high numbers of medical "outliers" on its surgical wards, Trust B also experienced problems in this area. Admission books on each ward give some idea of the scale of the problem. The admission books of Trust B do not provide the same information as those used in Trust A and this means, therefore, that some degree of caution is needed when assigning patients to particular categories or specialities. Crucial information is missing from the admission books of Trust B (including diagnosis) so care is needed in assigning patients to specific categories. It will be remembered that in the case of Trust A information concerning diagnosis and admitting consultant, when taken together, constituted reasonable grounds for assigning a patient to a given speciality. In the case of Trust B all that could reasonably be used was the admitting consultant and this fact taken alone is not necessarily confirmation of the validity of categories used. Nonetheless, even though the information needs to be interpreted with a greater degree of caution, it was still possible to gauge the extent of the problem with outliers. The admission books of both surgical and medical wards were utilised in order that it would become apparent whether the problem of inappropriately placed patients was a hospital-wide phenomenon or whether surgical areas were predominantly affected. Below is the data from two medical wards B4 and B5. On initial appraisal of the admission register on ward B5 the following information was obtained. The number of patients admitted over an approximate twenty-five month period was 1403. Of these 298 patients` specialities were unclear. These 298 are categorised thus (table 4.4 below):

Table: 4.4. Admissions to Ward B4 by Outcome (17.9.99-20.10.01).

Destination.	Number	Destination.	Number.
Definite medical:	119	Transfer to other medical ward:	5
Transfer to surgical:	100	Transfer to rehabilitation:	18
Surgical consultant:	2	Transfer to ENT:	10
Orthopaedic transfers:	23	Unknown speciality:	2
Unknown consultant:	3	Transfer to Woodlands:	1
Transfer to unknown ward:	8	Transfer to other medical ward:	2
Transfer to N. Staffordshire:	1	Psychiatric referrals:	4

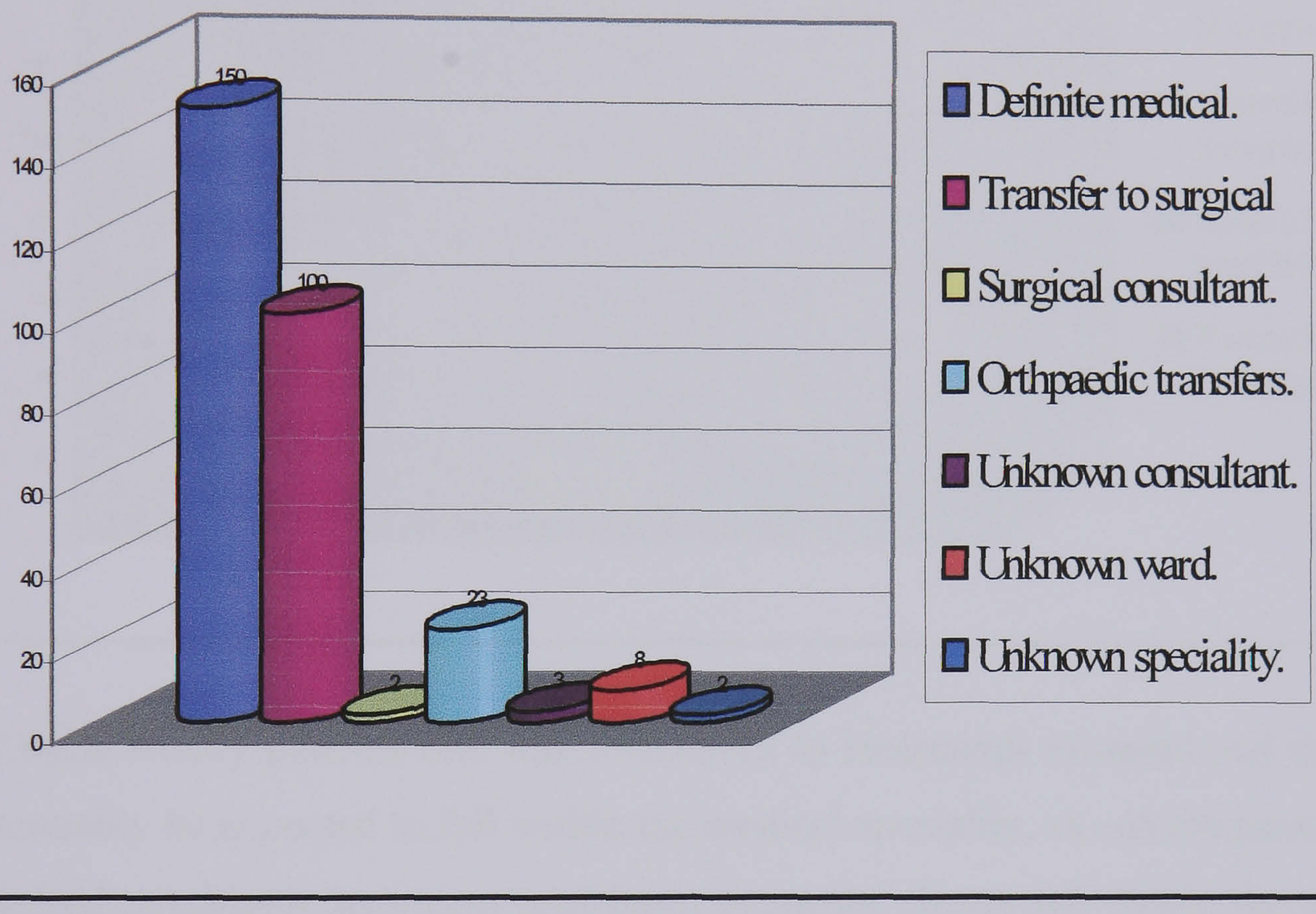
The data may be further reduced by amalgamating the number of transfers to specific medical wards, and amalgamating the surgical consultant and the ENT transfers both of which would seem to suggest that these patients warranted surgical rather than medical intervention. Thus, the number of definite medical patients rises by an extra seven from 119 to 126. There is also the question of those patients who were transferred to facilities offering rehabilitation. Of the 18 patients requiring some form of post-acute therapy, 15 required orthopaedic or general rehabilitation, one patient required rehabilitation following a cerebro-vascular accident and one person required rheumatology rehabilitation. One person required rehabilitation at a certain ward the exact purpose of which is unclear although it may be neurological rehabilitation. Thus, the vast majority of patients requiring rehabilitation could have been admitted as a consequence of medical conditions and have therefore been included in this category.

The position concerning the exact number of inappropriately placed surgical patients on ward B4 is more difficult to ascertain. Although the number of patients transferred to surgical wards was 133 (transfers to surgery, ENT and orthopaedics) this picture is misleading. Ward B5 had no side rooms and as a consequence of this a number of patients with infectious medical conditions may have been moved into immediately available side rooms hence distorting the figures. ENT transfers commonly arise as investigations of respiratory symptoms necessitate the use of equipment provided by ENT wards but the final diagnosis may still be medical. This group has also been included in the medical category. The transfers to the "not known" ward occurred because many of the ward names have been changed and this ward no longer exists. It proved impossible to find out its speciality. The category of "unknown speciality" arose as a consequence of incomplete information contained in the admission register.

The medical wards at Trust B routinely send a small group of their patients to other hospitals such as the Woodlands, North Staffordshire Infirmary and the Heartlands Hospital, so that they may undergo surgical procedures and specialist ventilatory techniques to correct or ameliorate thoracic conditions. Since the primary pathology is still considered to be medical rather than surgical, these patients have been included in the former category. Thus, out of the 1403 patients in the admission book 1105

were apparent immediately as definite medical patients. Of the 298 patients whose status was unclear, a further 160 of these were subsequently adjudged to be medical giving a total of definite medical patients of 1265. This gives a total number of unknown patients of 138 whose status cannot be determined with any certainty. This is given in figure: 4.1(below).

Figure: 4.1. Admissions to Ward B4 by outcome: 17.9.99-20.10.01.

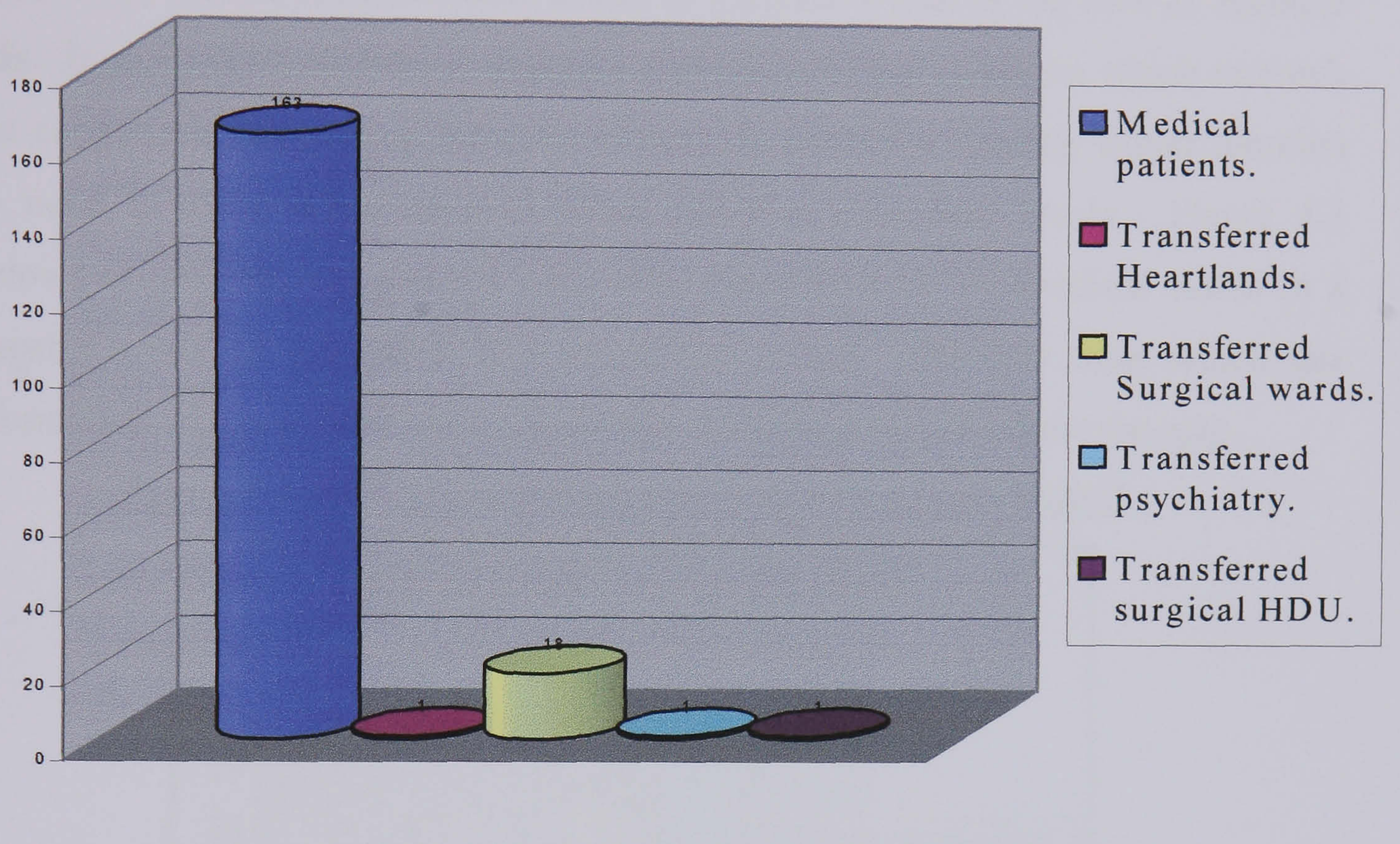


This indicates that of the 1403 patients admitted to ward B4 in a twenty-five month period 138 of these had uncertain status in terms of their speciality. This represents 10.1% the total or 4.9% per annum. Although this is probably too high there are other sources of information, which may be considered in an attempt to arrive at a more realistic figure. All that can reasonably be said is that surgical patients do take up medical beds, the question of the degree to which surgical patients block these beds and the reasons for this have still to be answered. Ward B5 is a similar medical speciality to B4. Its admission figures for almost a four-month period provide some insights into the number of beds used by medical patients.

In this period there were 182 admissions. Of these 162 were judged to be medical patients on the basis of the admitting consultant and the outcome of the hospital

episode. This left twenty patients with disputed status. The outcomes and their frequency are given in figure: 4.2 (below).

Figure:4.2.Admission figures by outcome: ward B5, 9.7.01-26.10.01.



Of these twenty patients one was transferred to Heartlands Hospital and thus can reasonably be expected to fall within the medical speciality, as can the person who required psychiatric treatment (self-harm or mental illness fall within the medical remit). This leaves those persons transferred to surgical wards and the one individual transferred to the surgical high dependency unit (HDU). This illustrates the changing nature of illness. This person may well have been diagnosed initially with a medical condition but subsequently required surgical intervention. For the purposes of this discussion, therefore, this person is classed as a surgical patient.

Regarding those patients transferred to surgical wards, there were in a four-month period, 18 such cases. If one analyses this figure this gives an average transfer rate of patients to surgical wards of 4.5 per month. If this is multiplied by 24 the number obtained is 108, roughly the same transfer rate per month as ward B4. Ward B5, however, has side rooms.

It would seem that the necessity of transferring patients from medical to surgical wards cannot be explained solely by either the need to isolate infectious individuals, or by a change in diagnosis (including the terminal stage of illness). Although these factors undoubtedly exert an influence on bed use they cannot explain all instances of peripatetic patients. The only other significant reason why patients are moved from medical wards to surgical wards is the lack of medical beds. In examining admission registers from the surgical wards on which research was carried out the picture becomes clearer, in particular (during winter months) the need to make some surgical wards temporary medical wards. Figure 4.3 (below) shows medical patients who were transferred to non-medical wards in a snapshot covering four days of a seven day period. The lists from which this information was compiled were not always available hence the three day gap.

Figure 4.3 Medical outliers on non-medical wards in Trust B.

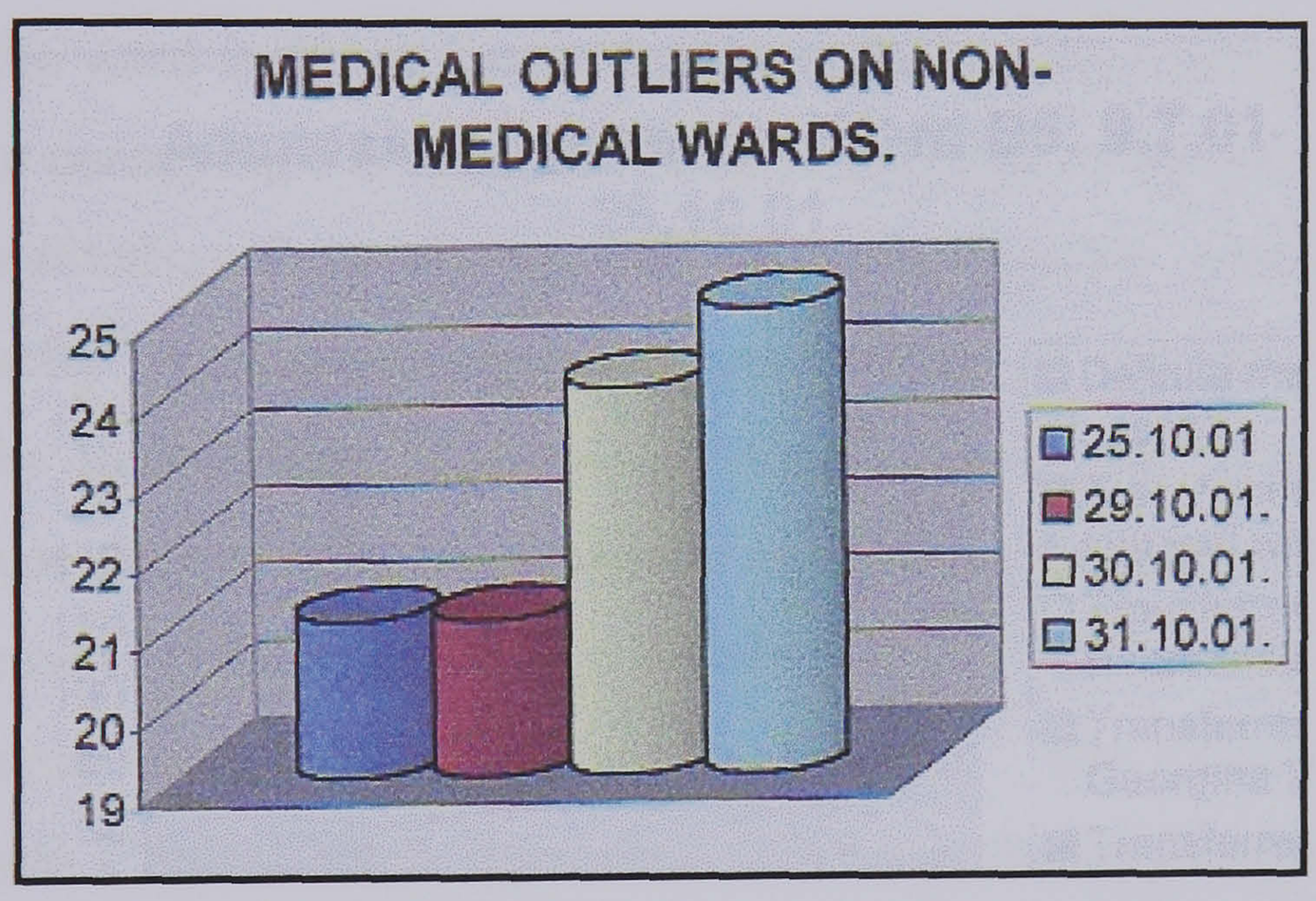


Figure 4.3 indicates that there were between 21 and 25 medical patients on non-medical wards. Since the data is for the month of November it may be that the rising numbers indicate the onset of winter pressures.

4.5 Summary.

Trust B suffers from many of the problems faced by its counterpart in that at certain times of the year there is a peak in the pressure that both Trusts daily face to meet the demand for throughput. Medical patients do end up on surgical wards despite attempts to diminish the stress that this involves for patients, relatives and staff. In the following section, communication and its effect on bed use will be discussed.

4.6 Examples of delayed or failed discharge in Trust B.

In the time spent with the discharge liaison nurses at Trust B and on the wards a number of incidents of concern were expressed by members of staff. These vignettes highlight the need for improved communication and annulment of knowledge deficits and procedural irregularities that serve to compromise the effective operation of the discharge planning process. The problems encountered indicate that communication is liable to breakdown for a number of reasons and are discussed below.

Managers within Trust B felt it necessary to monitor the type and number of patients who experience a delay in discharge arrangements as a consequence of non-therapeutic delays. Like Trust A, a delayed discharge form is completed weekly by the ward staff and forwarded for auditing. Any patient who is fit for discharge but occupying a hospital bed must be included on the form. In addition a concerns monitoring form allows staff to make specific complaints. These provided useful information regarding perceptions of the discharge planning process. The Inter-Agency Monitoring Group's reports are worth examining at length because they provide an indication of both the breadth of involvement of staff and the nature of the complaints. Between April 1999 and March 2000 a total of 27 concerns were raised involving 26 patients. The majority of concerns originated with Clinical Nurse Specialists (CNSs) or Social Services Departments (SSDs). Of ten headings used in the report, nine applied directly to the discharge of patients across the interface. The headings were general communication (5), delayed SSD response (1), SSD not informed of discharge (4), no dressings (3), inadequate discharge information (1), incorrect address (1), poor discharge planning (1), differing perceptions (1) and one "inappropriate concern" (see below). Even the final category of "day case surgical issues" (involving nine patients) are concerned specifically with physical and educational preparation of patients and staff for discharge planning. The instances in this report will be quoted at length since they provide some idea of the pressures staff are under and the elementary and horrifying mistakes staff can make. Some of the incidents recounted also illustrate the fine line in decisions that must be made concerning whether or not to discharge a patient.

The first incident concerns the discharge of a patient who had had extensive pre-discharge input from a variety of agencies with a resultant complex package of care (POC). The patient had been discharged but following repair of a water leak in the patient's home the supply had not been turned on. The social worker could not be contacted and the nurse decided that the patient should be returned to the ward. The social worker did contact the ward but this came too late to enable the patient to return home as the ambulance crew were already committed elsewhere. The patient remained in hospital overnight and was discharged the following day. The author of the report noted that "in hindsight, the patient could have remained at home where her water could have been turned back on...and she could have waited for carers to visit". The assessment of the author is only legitimised because at that time it was known that the social worker contacted the ward. The nurse, presumably acting with the safety of the patient in mind, decided that since the social worker could not be contacted the patient would be safer on the ward. There is also something unfeeling in the assertion that the person should simply sit and wait for her carers. This example illustrates perfectly the tensions between organisational demands that bed use be maximised and the professional obligations of the nurse. If the person had been allowed to wait for her carers and something had happened then the nurse would have been castigated for compromising safety. Since safety was uppermost in the nurse's mind a mild rebuke follows for ill usage of a bed.

The second incident raises issues concerning fragmentation of care, poor communication and accountability and responsibility. The ward staff were, in this instance, accused of failing to take responsibility for the discharge. The Occupational Therapist (OT) was a key figure in this because she liaised with all outside agencies regarding care arrangements and believed that a discharge date was organised with the SSD. Ward staff then arranged the discharge as instructed by the OT. The patient was then discharged with the ward staff believing that a Health and Safety Assessment would be performed that afternoon. The SSD believed, however, that the phone call represented an enquiry only and that no definite discharge/assessment date was arranged. This was discovered accidentally when the SSD rang the ward for an update and members of the SSD then made an urgent visit.

The report concludes that the nurse was at fault since s/he had allowed the OT to make arrangements when clearly the responsibility to oversee discharge lies with the discharging nurse. Another nurse commented, however, that communication with SSDs was "very poor" and cited lack of funding as a major problem. Although the findings of the report may be true, it is clearly not improbable (given other examples) that poor documentation, a reliance on informal verbal communication, poor communication with the SSD and a willingness on the part of the nurse to delegate responsibility in times of increased workload all played a part in the untimely discharge of a vulnerable person. Another example of delegation concerned a nurse who had discharged a patient with the blessing of the son but the nurse then agreed that the son should contact the SSD. In one instance the staff nurse believed the patient was able to make the arrangements. The Social Services Department (SSD) was, therefore, by-passed and they were contracted that same evening by the carer requesting resumption of services from home with little notice.

There were a number of examples from both Trusts concerning failure to notify relevant agencies of changed circumstances. The third incident concerns the arrangement of a complex Package of Care and carers arriving at the patient's home but being unable to obtain an answer. The carers later learned that the patient had in fact been transferred to another ward rather than discharged.

There are also examples of inconsistent information being given to other agencies. In one instance a nurse rang SSD to request resumption of a package of care and was told that the SSD needed seven days notice and an OT report for a complex assessment. Although the nurse had already booked an ambulance when she rang, the agreed notice period for resumption of a POC is 48 hours. It was also pointed out that the patient's carer was on sick leave. Other examples of poor communication include examples of messages being left and subsequently being untraceable and people being unable to obtain information from either hospital staff or community staff. Others include SSDs not being informed of either patient's admission or discharge and inadequate written information being given to community CNSs.

One incident is, however, puzzling. Members of staff on a ward within Trust B

arranged the discharge of a patient to a nursing home without informing the hospital SSD who were funding the placement. The case was discussed at panel (see below) and a nursing home was found. It is unclear whether this patient was discharged and then discussed at the SSD panel or discharged following discussion. What is clear is that with the relatively infrequent meetings of the panel, some delay in discharge was inevitable and it might be a more satisfactory arrangement if discharges were arranged and issues of funding decided once the patient, carers, hospital and nursing home staff had decided on a suitable placement. This is not intended to exclude social workers, merely to assert that seemingly professional pique does little to resolve bed crises or funding and the transfer of a patient to a suitable nursing home will ensure better use of acute beds whilst funding is sorted out. Whilst social workers should be involved in all aspects of the discharge planning process, a rigid adherence to rules and funding mechanisms does little to encourage the kind of innovative flexible team working which will help ensure that the National Service Frameworks are adhered to and bed use maximised. Ideally all individuals who are medically fit should be transferred to intermediate or continuing care facilities where such arrangements can be made and since certain care homes already have the facilities to admit patients requiring ongoing non-acute care perhaps the funding debate should be removed to this arena.

A further incident concerned discharge from hospital of a patient who had an existing POC. This patient was declared medically fit and a referral was made to recommence the POC. The social worker made arrangements to visit the hospital in order to assess the patient but the ward contacted the patient's care providing agency before this date, found that the POC could be recommenced and duly discharged the patient before the social worker had assessed the patient. The report concludes that "the ward staff did not adhere to the discharge policy by bypassing SSD. Although carer resources were available for the patient, contract arrangements with care agencies are under the instruction of SSDs only".

This final contention merits examination. If care arrangements were already in place then why could the person not be discharged until the SSD had given their consent? Inevitably the question of safety arises, the primary purpose of the social worker visiting the hospital before the discharge of the patient is to assess and look

for changes in functional ability and social circumstances. There are plainly some patients, however, who could be assessed at home without compromising safety and ensuring that they are placed in a timely and appropriate manner. Adequate initial assessment by nurses and other staff may ensure that these patients are identified.

A further incident concerned a patient discharged with no arrangements made to restart homecare and no OT assessments during admission. A commode was urgently needed and SSD was not informed of either admission or discharge. The patient`s wife wanted him to return home and requested a commode at the last minute but stated that the lack of a commode should not prevent the patient from coming home. The report notes:

> *"These arrangements were not satisfactory. It appears that the patient`s toileting abilities were not considered sufficiently to realise that if he needed a commode upon discharge then he would not be able to wait for one to be arranged in the community after discharge had taken place. The staff nurse apparently overlooked the restarting of the POC which consisted of seven `get up calls`. It seems that the consultant's wish for discharge and the wife's eagerness for a return home brought about a discharge that could easily have resulted in failure and for which the discharging nurse would have been held accountable".*

Once again, it seems that poor assessment (both initial and continuing) by nursing staff was in part responsible for this. Other factors include the confluence of negative influences such as consultant wishes and wife's eagerness, which must have put pressure on the nurse to discharge the patient. Nonetheless, omission of assessments and failure to restart relatively simple care packages cannot simply be subscribed to an attempt to please everybody. Such failings may be the result of poor documentation – did the nurse know that a POC was already in place? The nurse may also have been relatively junior and, therefore, lacked knowledge and experiential resources necessary to both ensure safe and timely discharge and to use clinical judgement as well as making the case against discharge with the consultant concerned. A nurse opined, of relationships between medical and nursing staff, that

"... Doctors say that patients can go home without consulting nurses about home circumstances. This makes it look as if nurses don't want patients to go home. [There is] little support from line managers as they are very stressed dealing with their own problems. [There is] lack of reward for staff achieving targets"

There are numerous examples of information being given but not received, information not being transmitted at all, or information which has been apparently received but not acted upon. Incidents within this category illustrate the need to ensure accurate transfer of information both across professional boundaries and between different modes of information transmission. It would seem that many messages are relayed to ward staff via telephone but are not subsequently recorded in a more permanent medium. In some cases ward staff, community staff and staff of SSDs claim that they inform the target organisation or agency and leave messages. Receptionists, duty social workers and nursing staff cannot remember messages being left and there are often no records either in nursing notes or message books used by SSDs (for example) to log messages. This can involve hugely insensitive phone calls to family members such as on one occasion the bed management team telephoned a person's family to inform them that a bed was available. They were informed that the person had died a week earlier (this has also occurred at Trust A).

The use of informal channels of communication was also noted. The question of the desirability of this practice is obvious. Equally obvious is the ad-hoc nature of arrangements that are made to facilitate discharge of patients. In certain instances informal mechanisms lead to duplication or failure to take responsibility for information and to anticipate adverse consequences. There were a further three incidents documented in which informal enquiries by carers led to services being resumed. A further incident demonstrates not only a reliance on channels of communication considered informal in the extreme, but also a failure to verify information obtained. This also indicates that not all hospital staff are aware of the need to give at least 48 hours notice to the SSD before a patient can be discharged in order that the care package can be resumed but that equally not all SSD staff are aware either.

Reliance on informal channels of communication was emphasised when a lady attended A&E but was not admitted and went home. In the period during which the lady was attending A&E, the "meals on wheels" driver had contacted the SSD and informed them that the lady had been admitted. Her services were subsequently suspended. Ideally, the hospital should notify the GP and SSD of admissions or discharges. This does not always happen. Although one would not normally consider information from this source to be formal, the information could have been potentially useful. Either the driver concerned or certainly the social worker should have checked the veracity of the information provided and some form of formalised feedback mechanism may have proved invaluable in this instance. Organisational pressures may also be in evidence here since cancellation of services in this instance may mean that they become available to someone else thereby easing the pressure slightly. Given these pressures, it may be that they serve to remove the need to ascertain veracity of information.

Concern was raised concerning the discharge of a patient to a residential home the day before he was expected by the SSD and the home staff. This person was in a very poor condition on arrival (clothes were soiled). Investigations revealed that the Senior House Officer (SHO) reviewed this person's fitness for discharge twice but that the ward staff had no record that discharge had been arranged for another day. The situation was made worse by the fact that there was some confusion amongst the ward staff as to whether this person's destination was a nursing home or a residential home. The ward staff appeared to think it was a nursing home. Whether this confusion over the type of accommodation was used as a justification for the poor state in which this person arrived there is unclear. One implication would seem to be, however, that this person was inappropriately placed in a residential home when requiring nursing care. The literature indicates that through the manipulation of meanings and access criteria such inappropriate placements occur intentionally in a significant number of cases (see The Climbie Report 2003, Legge 1999, p. 8-9). Although the day of the week on which this occurred was not specified, this may have been further exacerbated by the phenomenon of the "Friday afternoon clearout".

Two further incidents serve to highlight the manner in which the organisational

demand for throughput, knowledge deficits in the area of discharge planning coupled with persons` eagerness to return home can combine to compromise patient safety. This incident form detailed the fact that the ward staff had only requested a reinstatement of existing services. Following discharge, this lady was found to be confused, non-weight bearing (i.e. not fully mobile) and not eating. The warden of the sheltered accommodation was contacted by the ward staff and was said to be happy for this person to return. The ward staff claimed that this lady was not confused and was mobile with a frame and assistance. She was apparently seen by the medical team the day before discharge and they presumably gave their consent to the plans made to send this lady home. It was apparently subsequently accepted by the ward staff that in retrospect, a reassessment of functional and cognitive capabilities may have been more appropriate since this person's general status must have worsened prior to admission and must have rapidly deteriorated post-discharge. The author of this report also notes that:

> *"Patients` ability to disregard information given to them both verbally and written should not be underestimated in their eagerness to return home".*

This was supported by assertions made by a CNS. She claimed that, in their eagerness to return home, patients would either play down the severity of their symptoms or fail to disclose them. This meant that both the patient and the carer left hospital with unrealistic expectations concerning their ability to cope within the community. The potential for early readmission is only too obvious. Although there would seem to be an element of manipulation or interpretation of events by service users in order to produce an outcome that they view as more favourable to them, this incident fails to acknowledge the influence of other possible factors. There is no admission of the fact that the person's status may have worsened as a result of hospitalisation or of poor assessment and discharge arrangements.

The second incident in this category concerns a patient who was referred via the Community Liaison Sister for a wound check and removal of sutures following a hip repair. The district nurses were sent to this person's home by the GP to assess complaints of constipation for four days. On arrival, the nurses found that the patient had a diagnosis of colonic cancer with liver metastasis, severe gravitational

oedema of the legs and possible lymphadenoma. None of this information was highlighted in the referral letter the nurses received. According to the district nurses, this lady clearly needed an assessment on discharge and not two weeks later as requested.

Differing perceptions are also mentioned as a potential cause of failed discharge due to conflict and the incorrect targeting of resources. In one incident (although the complaint was initially raised by a social worker) a CNS claimed that the patient would receive twice-daily visits but the District Nurse (DN) claimed that "*if necessary*" the patient would receive twice daily visits but this would follow reassessment in the patient's own home. The DN felt, having assessed the patient, that the CNS input was quite excessive since the patient required daily dressings to a "small superficial pressure sore and care to an indwelling urinary catheter". The family and patient agreed to daily visits.

Mentioned above as "inappropriate concern" is the following incident. A patient was discharged from a ward and contacted the SSD. He told SSD staff that he had had a heart attack and was discharged without being offered any services. He further claimed that he had no bread or milk in the house and did not have the strength to go out and get any. Investigations ruled out any evidence of myocardial infarction in this case and the individual was apparently fully mobile and completely self-caring. All staff were exonerated in this instance, which shows the manner in which inappropriate use of services by patients and families may occur. Other example of this are to be found in CIB: 8, CBD: 9 and CBD: 3(critical incident, Trust B). The first concerned a patient who had repeated operations for lower limb circulatory problems and eventually had both lower limbs removed. He could not or would not leave hospital since he was allegedly unwilling to participate in exercises designed to strengthen his upper body so that he could lift himself up in his wheelchair and transfer from bed to chair. He and his partner were offered a flat but they claimed that this was not big enough and they wanted a three-bedroomed house. Thus, this man was delayed in hospital until such time as the accommodation of his choice became available. The second concerned a patient who was independently mobile having been assessed by the physiotherapist. He was about to be discharged having refused a care package and then said that he

now wanted a care package. The third critical incident concerns the manner in which both GPs and families collude to get a person admitted to hospital. This lady was admitted with a provisional diagnosis of a cerebro-vascular accident (CVA) having been assessed by her GP as having possible right sided weakness and an inability to swallow. On admission there was no evidence at all of a CVA and indeed the patient was independently mobile on the ward. The underlying reason for admission to the secondary sector was that the family were unable to cope at home and felt that this lady needed long-term residential care. Many GPs and family members use the possibility of admission to hospital as a means to get long standing problems resolved quickly, a phenomenon noted in Trust A. The lack of possible alternatives to playing the system, the lack of alternatives to admission to hospital means that the question of alternative capacity to avoid admission and avoid delays once admitted needs urgent consideration. A summary of common reasons for problematic discharges are listed in table 4.5 below.

Table: 4.5. Reasons for Problematic Discharges within Trust B.

Reason.	Number of instances.	Examples.
Failure to notify.	Eleven .	Failure to notify SSD and use of relatives as unofficial channels, ward and home arranged discharge between them. Not discharged but transferred to rehabilitation – SSD not informed. GP failure to notify hospital of patient death. Insufficient reinstatement time. Communication between nurses and district nurses: no evidence of referral having been made, or speaking to untrained staff (x3). Facsimile problems (x2). Problems with information and a specific SSD (x2),
Poor standards of care on discharge.	Three.	Transferred to residential home – soiled, dishevelled. Patient transferred to residential home, not eating, confused, non-weight bearing. Woman discharged with advanced cancer- poor assessment.
Failure to document/refer.	Twelve.	Ward staff failing to write in notes re need for social services to see before discharge. Not informing district nurses. Incorrect addresses (x3). Failure to refer to district nurses (x3).
Intentionally playing the system.	One.	Discharged from CCU, misrepresenting diagnosis in order to elicit services.

It is important to note that the category of "intentionally playing the system" has only one instance within it and this concerned a patient. In case the reader should think that this is an example of professional loyalty on the part of the researcher, the reasons for the categories will be set out below. "Failure to notify" is clear. This category contains all instances of failure to signal intent or current arrangements

through official channels. As such, therefore, it covers all examples of failure to notify social services (the most common error) as well as those instances where one party alleges that a second party was notified but no record exists. Thus, this category contains all examples of non-communication or instances were communication has broken down. The exception to this is the category "failure to document". This warranted inclusion as a separate category since it concerns nursing assessments and the time nurses have to carry out these assessments thoroughly. Since the assessment of the newly admitted patient by the nurse is often the first time that a health care professional has any opportunity to gather information about a patient, this is a crucial stage in the process of ensuring that the person's health care career progresses smoothly from this point.

Also, failure to notify is not the same as failure to refer. It is the case that failure to notify occurs regarding change in circumstances. This commonly occurs with social services who are invoked very early on in many cases because of the length of time it takes for the process to come to fruition. Thus, initial referral is generally not a problem but subsequent events of keeping the two professions informed of each other's intentions and progress generally is. The situation regarding the district nurses (DNs), for example, seems to be different. In the case of the DNs, subsequent events post-referral are generally non-problematic since the DNs are autonomous nursing practitioners who can, to some degree, make up for deficiencies in the health care system. The problem with the DNs is the referral process. Some patients are referred to DNs for trivial things and some are not referred at all. Also, DNs and other GP based community staff rely heavily on basic information being supplied by nursing staff. This is not information concerning diagnosis, interventions and their part in the plan of care, although this is important. By basic information is meant such things as the patient's correct address and in particular the postcode. The importance of this was made apparent in two instances. A member of the discharge co-ordinator team at Trust B was a nurse who was formerly based in the acute facility. She claimed that until she left the hospital she had no idea that the postcode could be so important in terms of finding the right address quickly and saving time between visits. On one occasion (in which a person was visited at home) the researcher found the right address but could not gain access. Upon asking a workman why this was he claimed that there

was another place with the same address about two miles away, it took an extra ninety minutes to find it. This can according to community based staff happen quite regularly if the address is incorrect and the postcode is not included.

The category of playing the system does not apply only to relatives and their families. Although certain relatives or patients undoubtedly do attempt to manipulate the system for their own ends, these examples are immediately obvious. Information gathered reveals that some staff also seek to play the system, some do it intentionally and some, arguably unintentionally. By playing the system is meant an attempt to gain a favourable outcome for oneself or one's occupational group. This is evident in some of the examples discussed above (and was evident in Trust A also) and will be further evident in that which follows. The concept itself needs further qualification since many nurses would argue that they only act in a manner, which attempts to guarantee a favourable outcome for the person in their care. Whilst this may be true in the vast majority of cases, at least some of the data suggests that nurses may reconceptualise care so that their interpretation of what is best for the patient tends also to be what is best for themselves as a group. Thus, in this manner it is possible to assert that one seeks to act in the best interests of the patient whilst acting in a manner that serves the interests of groups.

Thus, there is another possible agenda in the arrangement of discharges, an agenda moreover which bears some resemblance to the subversion of the caring discourse discussed in the literature review. It is sufficient at this point to say that although some patients and relatives do deliberately and transparently play the system in order to ensure a favourable outcome, they do so because they lack those other options which are provided to health care staff who are familiar with the discourse of health care both in its most general sense and in the specific sense of the organisational contexts in which it must be applied. That is to say, health care staff can equally transparently and intentionally play the system, but the majority of attempts by health care staff to ensure a favourable outcome are couched in the language of patient benefit. Whilst patient benefit is obviously a powerful mediator of the actions of health care professionals, it is this perceived and partial benefit that may cause nurses to confuse or conflate organisational and individual benefit in order to cope with those same organisational pressures. This may be termed

.entionally playing the system.

4.7 Summary.

In the above instances it seems that a number of factors contribute towards poor communication. These factors range from the failure to communicate basic written information, failure to adequately assess vulnerable individuals accurately, failure to give notice and indication of intent, knowledge deficits concerning organisational policy and the role of the individual. The likelihood of such negative outcomes occurring is enhanced by perceptions staff have of other staff, the demand by the organisation that throughput should be optimised, and insufficient time to anticipate likely problems through the planning of care with all concerned parties. These in turn raise questions concerning levels of education among staff and their ability to maintain standards of care of a sufficiently high quality in such an atmosphere.

Other critical incidents from Trust B include a failure to involve carers resulting in confusion over whether an assessment (in this case by the OTs) was really necessary (CIB: 4). The family had initially voiced a possible indication of need regarding help with washing and dressing but they had since revised their views because the patient was improved beyond their expectations. The patient himself, however, claimed that he needed help to look after his wife and yet the son claimed that it was the wife who carried out caring duties. This is an instance of poor assessment initially, in particular, failure to carry out assessment of the carer. Also, it illustrates the need for nursing staff and others to effectively elicit information from relatives concerning their perceptions of changed circumstances. There is also the issue of correct targeting of resources since this patient could have been discharged without an OT assessment. A staff nurse claimed that OTs do hold up the process by demanding assessments which she felt were either unnecessary or inappropriate at a given time in the patient's hospital career (CIB:1).

This was highlighted by anecdotal evidence volunteered by a member of staff (CIB: 5). A member of her family was admitted to Trust A and the family had difficulty getting her discharged because of the insistence on an assessment and case conference by the OTs. This was despite the fact that the place of domicile already

had all the aids and adaptations necessary for the person to live safely at home with help from the family. This means that unnecessary referrals also cause problems for other departments such as aids and equipment providers.

4.8 The role of the Discharge Co-ordinator Service.

The discharge co-ordinator service was originally part of the medical directorate within Trust B. The three members of staff will now help with any complex assessments with which nurses or other health care professionals experience difficulty. One member of this team also carries out an audit of clinical concerns raised by any member of the hospital and community staff. Whilst Trust A has approximately twenty-three discharge planners based in the community and six hospital based nurses, Trust B suffers a dearth of these resources. This has an impact on the role of these staff. Whilst their roles are synonymous despite the difference in name, lack of numbers means that the nurses at Trust: B do not have the luxury of becoming intimately involved with each discharge and can only offer advice in contrast to their counterparts at Trust A who can almost become the head of the health care team when discharge arrangements come to the fore. Because of this, the discharge co-ordinators (Trust B) are not seen in the ward areas and are not as visible as their counterparts in Trust A. This meant that it was difficult to assess the perceptions of other staff regarding the service they provide. Nonetheless, some interesting points emerged. The first was the constant change in the number and import of hospital policies in Trusts A and B. This was felt to significantly reduce the chances of optimal discharge planning arrangements purely because staff were unable to follow things through to their logical conclusion and were unable to take stock.

Secondly, the differing methods of ascertaining eligibility within Trusts A and B were mentioned. The Barthell Cognitive Assessment Scale used within Trust B was initially felt to be better since it was based more on Activities of Daily Living (ADLs) and, therefore, interpretation of eligibility was not fraught with the same potential for subjective bias as the system used in Trust A. The participant agreed but then claimed that vagaries of interpretation could still occur (especially in the assessment of toileting needs). She also provided documentation, which showed

that this assessment tool can be used to husband resources. A staff nurse had complained that some patients were given a cognitive and functional assessment rating that was too high, i.e. over optimistic. The nurse appealed and some people were reassessed and their score reduced. Rating an individual too highly is a value judgement that enables funding to be reduced in terms of social care, which is needed but the cost to health care will increase if the assessment results in a failed discharge and consequent emergency readmission.

The role of the Discharge Coordinators was misunderstood by the majority of nursing staff. They were seen simply as step-down nurses. An example was given of an OT simply presenting the names of two people who needed to be moved as something of a fait accompli. The Discharge Coordinator felt that a more protracted discussion would perhaps have been more profitable. It seemed rather presumptuous of the OT to behave in this manner but on further examination this may have been due to the perception that a nurse should take the lead in matters like this as second to the medical staff in the hierarchy of the multidisciplinary team. In fact the very definition of "multidisciplinary" would seem to suggest that all members are of equal status and there is nothing heretical about an OT assuming the status of named individual or overall director of care. This serves to indicate the insidious manner in which negative perceptions accrue and become entrenched and the manner in which they may affect practical action. This was confirmed by the staff member who admitted that some people abused the system by means of which complaints were made in order to play the system and make one speciality appear to be more efficacious than another, hence increasing self-esteem of members in that group. It was noted that one DN sent in an above average number of complaints and that these were all headed "yet another failed discharge". The nurse has since been asked to moderate her language somewhat because such emotionalism was not felt to be conducive to good inter-agency collaboration

4.9 The role of the Medical Team in the Discharge Planning process.

Again the role of the medical team in the discharge planning process varies tremendously with some specialities and doctors both realising the importance of good planning and being committed to its implementation whilst others fail in these

respects. In a training day held at Trust B the perceived isolation of the medical staff in the discharge planning process was highlighted. A recurring theme was the fact that all grades of medical staff were felt to be uninvolved in the process. Comments included "consultants need to be encouraged to participate in the training", "I feel consultants need to be involved in the procedures/training course", "would have liked to have seen some of the medical [staff] also involved", "...it would be helpful if consultants could be present", "need to have more doctors and consultants to attend as well" and "as usual, no doctors, one of the main areas of poor communication and liaison".

An example of the rather dismissive stance that some consultants take concerning the discharge planning process was furnished by one incident on a surgical ward at Trust B. Following an operation, the patient asked "exactly what was done?" In answer to this the patient received a cursory explanation lasting no more than thirty seconds, which culminated with the assurance that there would be no more operations. The patient then asked if an ambulance could be arranged for the impending discharge. One of the doctors replied "Yeah, yeah, we can sort all that out" whilst the other doctor said "talk to the nurses". The impression was that responsibility for discharge planning is actively abrogated by some medical personnel and that discharge planning is not a field in which doctors care to get involved in. This seems to be especially true of surgery. Most medical and rehabilitation doctors are aware of the importance of good discharge planning but they in turn have frustrations over the time that it takes to complete assessments and arrange social care. Other examples of abrogation include CIB: 2, which was pointed out by a fatalistic member of the medical team and CIB: 7. From the 11th to the 20th December the doctors had written in the notes cursory comments followed by "awaiting rehab" or "still awaiting rehab", punctuated by "nursing staff to phone through referral again". If the numbers of exasperated exclamation marks in medical notes were proportional to a doctor's willingness to use his or her influence then the numbers of delays would be significantly minimised.

Because certain doctors chose not to become as actively involved in the discharge planning process as they might, it is hardly surprising that there is a lack of understanding among these same individuals regarding the correct referral

mechanisms. CIB: 7 illustrates this as well as the fragmentation of care that can result when there is considerable overlap of roles as more and more individuals become involved with particular patient groups or even bodily organs. At Trust B there is a lung cancer CNS, a tuberculosis CNS, a respiratory CNS, as well as the Macmillan Nurses and the Marie Curie Nurses. The lung cancer CNS deals only with primary tumours situated in the lung and not with metastatic deposits. One doctor advised that a patient should be given the number of the lung cancer CNS but this was incorrect and this advice was given because this consultant sees her as "his nurse". In fact, it was the community Macmillan Nurses based with the patient`s GP who should have been notified. Staff felt that it was confusing 'but you get used to it' but it also indicates that not everyone is aware of the policy.

4.10 Social Services, their role in the Discharge Planning Process.

Arrangements for the provision of social care through the Social Services Department of Trust B mirror many of the deficiencies encountered in Trust A. Allocation and assessment are perceived to be lengthy processes and on a number of occasions it is necessary to recommence assessment and care package provision if the period of hospitalisation is greater than one month. Three medical staff members complained about this. The situation is compounded by the fact that the Social Services panel which meets to discuss funding in specific cases meets infrequently and this creates a backlog of cases which are waiting to be dealt with and who must, therefore, remain in hospital until such a decision is reached. Furthermore, there are two panels whose members meet to discuss funding. One is a social services panel and one is a health panel. This seems to run counter to current government strictures concerning the need to amalgamate health and social care.

Although intermediate care facilities do, on occasions, provide a way out of such impasses, the number of such beds would never be enough to satisfy demand and as a consequence of this many people will remain in acute beds when they are past the acute phase of their illness and have been assessed as medically fit. Medical fitness is also in dispute within this Trust. There were instances encountered of patients requiring enteral feeding via a PEG (Percutaneous Endoscopic Gastrostomy) who

were deemed by social services personnel to be medically unfit and yet it has been observed that this type of treatment can be managed by a patient and their family at home once appropriate training and education has been provided by hospital staff. Further, complaints that social workers voice is the fact that they are often contacted on the morning of a discharge to restart a care package. Ward staff, however, maintain that they are aware of the need to give 48 hours notice of discharge to the social services staff.

Nursing staff in their turn feel resentful of Social Services personnel because pressure is exerted on them by patients who want to return home. They then become hostile to the ward staff when they are made to wait for social services assessments. Social services staff claim that there are a number of occasions in which reassessment rather than resumption of an existing care package would have been more appropriate, that ward staff are not taking direct responsibility for informing social workers of a patient's discharge, and poor nursing documentation.

4.11 The role of the Nurse in the Discharge Planning Process.

The perceptions of the nursing staff of Trust B and their role in the discharge planning process were varied when compared to their colleagues within Trust A. This, in part, was due to the different initiatives currently gathering momentum within the Trust and the manner in which these initiatives impacted on the nursing role. These can be listed as communication by the nurse (including documentation), the role of other PAMs (including care coordinators) and fragmentation of care.

One Sister described how she had tried to introduce standardised documentation to improve the discharge planning process but five years later the documentation still remains the same. This is an interesting assertion. Many nursing staff seem to think that simply by standardising documentation this will ensure that all necessary information will become available. This is not the case. What is needed is a method to ensure that nurses adequately complete documentation through thorough assessment. On occasions it was found that the standard of documentation was appalling. Either an initial assessment was only cursorily completed or it was not

reviewed on a regular basis. One example will suffice (CIB: 2). A lady was admitted for an operative procedure. On the admission form numerous information fields were either filled in with one word answers or not completed at all. Information not ascertained included the main carer, referrer's view of patient's social needs and the patient`s and relatives` opinions of present or anticipated home circumstances. Cursory information included "cooking – self", "shopping – friend", "laundry – carers". None of the reverse side of the form (dealing with referrals to other agencies had been filled in but since this lady was awaiting assessment by the rehabilitation team this team must have received a referral. She also had washing and dressing practice under the supervision of the OTs as well as a referral to an over 65s monitoring service provided by the District Nurses. It was, therefore, evident that the nurses were not filling in the initial assessment form or ensuring that it was reviewed and updated. This lady was eventually re-referred to the rehabilitation team at the insistence of the medical staff. What is apparent is that there seems to be no continuity between the initial assessment document and subsequent entries in the joint documentation/medical notes. Important social information is diffused throughout the notes. On another occasion (CIB: 10) a lady was admitted for repair of a prolapse. On discharge there was no writing in the notes, simply the hospital stamp. This lady was readmitted some time later with intestinal obstruction and multiple medical problems. At one point, nothing was written in the nursing notes for four days. It was, therefore, impossible to tell when this lady had been transferred back to the ward from the Critical Care Directorate or whether an OT referral had been made. Overall, it was unclear what stage in the discharge planning process had been reached.

This Sister also pointed out that there were some problems with Occupational Therapy referrals and that at one point the OTs complained that there were too many referrals and yet appropriate referrals were still being missed. The Sister wanted to institute a system of "blanket referrals" where nurses would automatically refer all patients so that nobody would be missed and likely problems relating to the functional ability of patients would be picked up early. It is doubtful whether Occupational Therapists would welcome such a proposal although it may indeed serve to solve the problem of missed interventions as far as nurses are concerned. It seems that, once again, sectional interests mean that the true, whole-

systems approach may never be realised. As an example of the type of referral that is commonly missed, a gentleman on a ward round was about to be discharged by the consultant. An out-patients appointment was arranged and it was assumed that this elderly gentleman could make his way to that appointment using public transport. He, however, said that he could not walk well enough to be able to do that which came as some surprise to the consultant. Checks afterwards revealed no evidence of a mobility assessment being undertaken (the section on mobility in the initial assessment document was left blank). Throughout his period of hospitalisation mobility was not documented as being a problem and yet it was found immediately before discharge that he uses a stick at home and cannot get on and off buses because of the height of the steps. The man was discharged and will need an ambulance for his OPD appointment.

What was immediately obvious in talking to nurses was the tension between the need to ensure holism and the equally pressing need to reduce workloads and pressure thereby maintaining group solidarity and cohesion. The argument for blanket referral mechanisms is illuminating in this regard since it seems like a reversion to a more primitive and yet seditious and all-encompassing form of logic. The logic runs along the lines of what must be good for one discipline must be good for all others and is itself born from a perception of others which is predicated on an understanding of one's own interests and unwillingness to understand operational intricacies. In effect the interface between professions is ignored. Instituting a system of blanket referrals might seem like the obvious answer to missed referrals but such an approach is illusory. It does not, as shown above, guarantee that all missed referrals will cease and will certainly mean that the workload of the Occupational Therapists would increase and that the number of inappropriate referrals would also increase. Yet this approach lends credence among nursing staff that nurses are not the cause of missed referrals, in this case quantity has a quality all its own. What is needed is not a blanket method, which would serve to exonerate one profession and submerge the other. What is needed is an instrument that takes cognisance of individual needs and is capable of ensuring that both appropriate and timely referrals are made. In effect, the assessment process needs to be reviewed so that true holism can be implemented, the holism which takes account of diverse and unique individual needs rather than the holism which treats

all individuals as members of a class and makes no attempt to differentiate between members of this class.

Morale in some cases was adversely affected by what was seen as the number of new regulations, more paperwork and perennial fear of litigation. One staff nurse commented that she didn't want any hassle. She just wanted to nurse patients and go home.

There was also evidence of the continuing divide which exists between community based nurses and ward based nurses. In discussions with a Clinical Nurse Specialist (CNS) it was noted that having experience in both acute and community settings was extremely insightful. This person said that she found herself sticking up for hospital nurses against community staff claims that a discharge had been mishandled. Community staff seemed not to appreciate that a patient's condition can worsen within a remarkably short time, a point also made by the Discharge Coordinators who claimed that alterations in a patient`s condition can make hospital staff the villains of the piece, that the patient wants to go home and will play the system to ensure this result, or that relatives feel that they can cope to a greater degree than they actually can. Hospital nurses on the other hand had little conception of the manner in which some people in the community are forced to live. Strategies should be implemented by means of which nurses can understand more of the lives of people in their care, to understand the social-rootedness of illness and those who suffer it. Furthermore, this understanding must be refreshed at regular intervals (perhaps through rotation) since it is only when one is periodically exposed to such stimuli that they retain their freshness and meaning and can act as an impetus for concerted action to improve practice.

Other problems within the domain of nursing included non-referral of patients to the Community Liaison Nurse. The referral method to the Community Liaison Nurse does seem rather confusing. Initially it appears that Trust B operated a similar system to Trust A in which individual nurses referred to District Nurses attached to the patient's GP practice. Now, however, all referrals are supposed to go through the Community Liaison Nurse who is based in the hospital. There are numerous examples from Trusts A and B which illustrate that a considerable

number of patients are not referred to the District Nursing Service whether through the Community Liaison Nurse or otherwise. Examples include patients being discharged without insulin syringes, dressings and information in the form of a letter. This was particularly serious in one instance since there was also a lack of information regarding the administration of medication which included insulin and morphine sulphate tablets. Some wards, most notably in surgery, have written discharge aftercare leaflets for patients to take home in an attempt to bridge the information gap across the primary-secondary health care interface. As one nurse commented, however, "written discharge aftercare leaflets are poor and less available for some types of surgery. Some staff forget to use these leaflets". The same nurse claimed that, with the closure of the Discharge Unit they felt that discharges were again less organised.

The solution apparently consists of repeated reminders to ward staff about the importance of adhering to policies that few staff have time to read. Again and again the reason cited is that the ward staff were too busy. The situation is worsened when one considers the practice of outlying medical patients to surgical wards or the transfer of patients to other wards within the same speciality. The Social Services Department has raised these concerns and notes that inadequate nursing documentation adds to the problem. One instance was noted in which ward staff prior to the transfer of the patient to another ward had not documented any social services involvement and this was not handed over verbally either. This meant that the receiving ward was not aware of any social service involvement. This was experienced personally when I was asked to transfer a patient to another ward and in the ensuing rush key information was not handed over.

4.12 Summary.

There are a number of important areas in which the discharge planning process is compromised as a result of poor communication. Poor communication arises because of poor understanding of procedures and policies, the lack of time, which all specialties have in the acute sector, the lack of understanding, which specialities have of one another, and the need to preserve group unity in the face of increasing and little understood pressures. Because of the lack of time, the lack of bed

capacity, and the constant change within the acute and community sectors, nurses, doctors, social workers and OTs alike retreat in to a world in which they can refuse to accept new referrals on the basis of their inappropriateness. The need to maintain group cohesion and to uphold sectional interests given this pressure means that roles are misunderstood and that stereotyping and inappropriate referrals are more likely to occur in an attempt to shift pressure and equalise workloads. The use of eligibility criteria is one method open to those staff who rely on such measurement tools. Currently, the whole interface between disciplines, which was supposed to liberate both staff and patients and ensure both equitable and equable standards of care and care provision has become a battleground in which various departments try and salvage as much of their budget as possible.

4.13 The role of the Occupational Therapist in the Discharge Planning Process.

Of all the visits that were made during the course of data collection the visit to the Occupational Therapists (OTs) of Trust B was both instructive and enjoyable. There are nine OTs in the hospital as well as an unspecified number in the community. The role is varied and includes staffing the four assessment beds for people who present in Accident and Emergency but do not need admission to an acute bed, they also work in A and E and liaise with the fast track social work team, there is also a bathing assessment unit staffed by hospital OTs. The staff used to carry out "heavy rehab" related to industrial assessment but changing demand patterns, time factors and staffing levels mean that this has become a luxury as has the assessment of certain kitchen needs. The caseload of each OT is about thirty people at any one time.

OTs readily confessed to becoming disillusioned because the depth of their role and the skills needed to carry it out were not understood, particularly by the nursing staff. All that nursing staff refer people to them for in the main seems to be washing and dressing practice and the demands made by their current workload and by social services staff (since every social services referral must be accompanied by an OT assessment). This means that this small group of staff can only carry out the barest essentials of assessment and treatment and this plainly violates their expressed wish to provide complete, holistic care. OTs are also rather misused

since it is the job of the OT (particularly when undertaking complex assessments) to assess the patient both cognitively and functionally and to identify problem areas. The intimate association between OT assessments and impending Social Service Department input means that a number of the ward staff see it as part of the OTs` role to suggest a particular type of care.

The caseload is further increased by what OTs consider inappropriate assessment requests. This highlights the fact that what is appropriate to one speciality may be considered inappropriate in others and also gives some idea of the complexities that need to be overcome if true multidisciplinary team working is ever to become a reality. Those people who are referred inappropriately from the standpoint of members of the Occupational Therapy Service are the bed-bound, patients who are unstable medically, patients who are comatose and patients who are still receiving intensive medical care. Although OTs consider such requests inappropriate given current numbers and workloads, the hospital policy states that a complex assessment should be carried out on these patients. Thus hospital policies serve to state the ideal situation but take no account of the degree of fluidity that can exist within the domain of acute health care. A satisfactory compromise was reached in which the OTs would liaise with the nursing staff until their input was deemed appropriate.

Regarding home visits, OTs feel that the ward-based staff understand little. Forty-eight hours notice is required to prepare for a home visit and yet OTs are routinely asked to arrange home visits with less than 24 hours notice. The OTs have to arrange paperwork, of which there is a tremendous amount, as well as security preparations, transport, medical consent and nurse liaison.

Documentation for assessment by OTs is excellent. It contains directed and pertinent questions and (if filled in correctly) would paint a much fuller picture of social needs. Because the OT documentation is precisely orientated to the functional capacity of patients it could be used to train nurses to ask the right sort of questions. There are still some elements of subjectivity in the OT documentation in that some patients would over perform or under perform depending on the outcome that they desired (either early or late discharge) but the OTs admitted that they can

normally see through such strategies. Once again it appears that nurses were not scoring the assessment scores properly and such assessments are now done by a specialist nurse. There were incidents of poor communication through all sectors of the discharge planning process involving the OTs. The final ignominy was that staff from ITU phoned the OT department one day and asked if they had any jigsaws that their patients could use.

4.14 The role of the care coordinator.

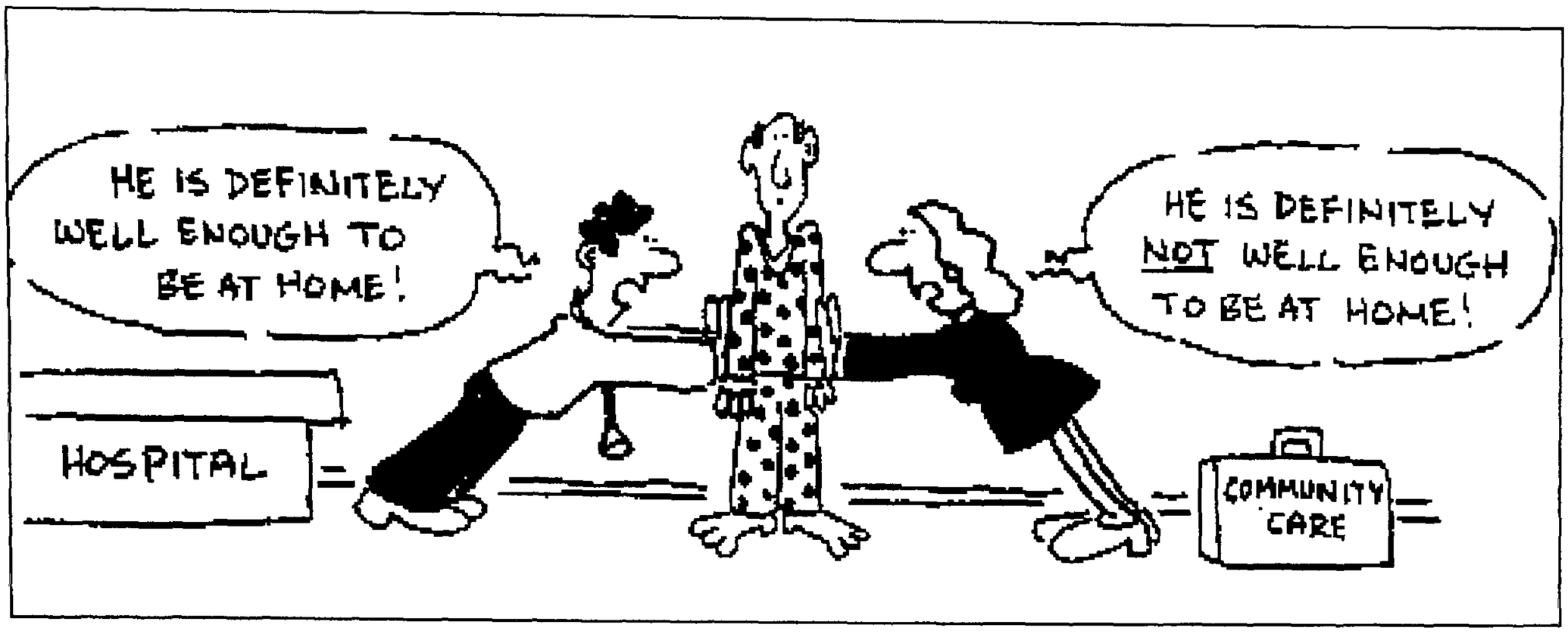
Trust B managers have piloted a scheme in which care coordinators are employed. The role of the coordinator is to attend ward rounds and doctors' meetings, gather information regarding patient management and circulate this information among the nursing staff. The rationale is that this would then free nurses to carry out direct patient care. Views concerning the service were mixed, one sister commenting that it would lead to further fragmentation of care and deskilling of staff. It was impossible to gauge the extent of threat to the nurses` traditional role. It was unclear also what the exact relationship was between the roles of the ward receptionist and the care coordinator but it appeared inevitable that some degree of duplication of tasks would occur.

4.15 Summary.

Both Trusts experience the same problems. Communication remains extremely variable due to demands made upon staff and this increases workload and administration but diminishes the amount of time available for its completion. There is a perception that patient expectations have increased and that these demands are not always realistic. The same disillusionment was found regarding SSDs both among medical and nursing staff because the processes of referral and assessment take too long and prevent appropriate bed use. The roles of key members of staff are not fully understood by members of other occupational groups and their potential and ability to speed up the assessment process is never fully exploited. The same degree of uncertainty regarding role and future direction was also apparent.

Having presented the findings from both Trusts involved in the data collection phases of the study, the following chapter will be concerned with a discussion of those same findings with reference to current literature on discharge planning and related fields. For information regarding the search frame used and date limitations of articles used in the following section, the reader is referred to chapter one.

Chapter: 5. Discussion of findings from Phase I and II of the study with reference to current literature.



5.1: Introduction.

This chapter contains a discussion of the discharge planning process encountered at the two Trusts examined in chapters three and four. The discussion will concern the salient points only as some of the points raised are not unique to individual sections of the decision trail but are common themes. These themes are appropriate bed use and delayed discharges, rehabilitation services and alternatives, fragmentation of service delivery, workload morale and standards of care amongst district nurses and acute nurses, issues of role, lack of knowledge, relationships between professional, doctors' role in discharge planning, community and acute nurses' role in discharge planning, social workers' role in discharge planning and communication in the discharge planning process. The discussion will refer to current literature on the discharge planning process (1998-2005). The literature cited indicates the widespread geographical nature of the discharge planning debate. Contributing countries include the Netherlands, Israel, Cuba, Switzerland, Australia, Canada, America, Britain and Scandinavia. Also, the literature is drawn from a wide range of appropriate specialities including stoma care, orthopaedics, terminal illness, vascular surgery, rehabilitation nursing, medicine and stroke management. The following section will again examine appropriate bed use in the context of delayed

discharge to detail how the situation has changed since the initial review of the literature was undertaken.

5.2: Appropriate bed use and delayed discharge.

Findings from the study reported here indicate that correct bed utilisation is problematic in both Trusts. Inappropriate referrals and admissions were generated by GPs because of poor knowledge or lack of community resources. Patients were inappropriately admitted by junior doctors who erred on the side of caution – once again knowledge deficits were a causal element. Lack of specificity in the assignment of diagnostic categories was also a contributing factor. Inappropriate admissions placed pressure on the acute care sector which was being squeezed between a lack of community resources and a lack of areas to appropriate areas to discharge patients to because of a shortage of rehabilitation beds and the under development of early supported discharge initiatives. The outlying of patients to other (sometimes inappropriate) clinical areas reduced the ability of both Trusts to deal satisfactorily with elective surgical and orthopaedic cases. Interestingly, pressure on beds may be linked to a rise in the incidence of nosocomial infection. Pressure on acute beds (which occurs all year – not just during the winter months) is directly responsible for early discharge, increasing the likelihood that such discharges will be poorly planned and will lead to early readmission. High bed occupancy rates also contribute to inappropriate referral to agencies such as the district nursing and occupational therapy services.

These findings concerning the increase in bed occupancy rates and the attendant consequences for the process of discharge planning are supported by data from the DoH which indicates that between the years 1998-2004, the average daily number of available and occupied beds in all sectors has increased significantly (DOH 1999, 2000, 2001, 2002, 2003). Figures for 2003-2004 reveal further increases with many specialities approaching the 90% point of occupancy at which they will be subject to regular bed crises (Bagust, Place and Posnett, 1999) with departments specialising in geriatric medicine enjoying a 92.2% bed occupancy rate. Glasby (2002) notes that "in the second quarter of 2001-2002 there were 7,065 delayed discharges…which accounted for six percent of all acute beds". Indeed Halfon and

Eggli (2001) assert that many studies have shown that between 15% and 50% of bed days are classed as inappropriate and that of these inappropriate days 52-82% was due to delays in the discharge planning process. Lambert, Verheggen and Pop (2002) suggest an even higher proportion of delayed discharges as they found that 27.4% of their study population were classed as inappropriate stays and of these, 51.5% were caused by external factors, the principal one being placement in another care facility. In Lambert et al`s study, over forty-five percent of inappropriate stays were due to factors which could be controlled by the hospital such as delays due to hospital procedures. They assert further that as many as 6000 hospital days could be saved if internal factors could be reduced by 50%. This is supported by findings from Lambert, Gooskens, Verheggen, Pop and Prins (2004) and Moya-Ruiz, Peiro and Meneu (2004). Shepperd, Parkes, McClaran and Phillips (2004) assert, however, that: "the impact of discharge planning rates on readmission rates, hospital length of stay, health outcomes and cost is uncertain".

Table: 5.1. Average daily number of available and occupied beds by sector, 2003-2004 (DOH 2004).

Year	Form	Sector	Available beds	Occupied beds	% occupancy
2003-04	KH03	All ward types	184,207	157,984	85.8%
2003-04	KH03	General & acute (acute plus geriatric)	137,277	119,312	86.9%
2003-04	KH03	Acute	109,846	94,009	85.6%
2003-04	KH03	Geriatric	27,431	25,304	92.2%
2003-04	KH03	Mental illness	32,410	28,391	87.6%
2003-04	KH03	Learning Disabilities	5,212	4,385	84.1%
2003-04	KH03	Maternity	9,309	5,896	63.3%

Thus, with pressure on beds actually increasing, it remains as important as ever to ensure that resources are managed effectively and used appropriately. It will be evident from the discussion which follows, however, that the complex interplay of referral patterns, patient characteristics (Chaboyer, Foster et al, 2002), community and hospital resources and "population ageing in the setting of widespread policy development that reduces availability and access to permanent institutional care" (Gray 2001) mean that each organisation must seek to maximise resource use in the context of these unique characteristics (Halfon and Eggli, 2001). There is not one solution for all hospitals; rather, solutions will be dependent upon a number of

variables. The discussion below demonstrates (with reference to current literature) that although attempts have been made to make the process of discharging vulnerable adults from hospital more rigorous, there are still fundamental problems in the way the basic processes are carried out and that each change made to the existing process causes distortions and system problems in other areas.

Hasan (2001) makes some telling points on the avoidable nature of readmissions. He claims that the number of admissions from specific groups do not (as mentioned above) reflect poor care but are an outcome of a dependent and medically unstable patient population. Improved community support and robust discharge planning, may prevent some admissions but not all. Finally, as Gray (2001) points out, no studies have addressed the prolongation of hospital stay as a method of reducing readmission rates. Targeted interventions with specific at risk groups may better enable them to be prepared for discharge and prevent readmission. Glasby (2002) notes that only the true integration of health and social care can resolve the difficulties associated with delayed hospital discharge.

5.3: Rehabilitation services and alternatives.

Discordance between the staff of rehabilitation facilities and acute hospitals was noted during both phases of the study (see, for example, chapter 3, section 6). Findings from this study indicate, however, that many participants suggest that this is what is wrong with the current referral system for access to rehabilitative care. They argue that access is severely restricted as it is and that it is unfair to pick and choose patients. Ward staff report that persons should be allowed access to rehabilitation simply to achieve throughput on the wards and yet this leads to situations in which rehabilitation beds are blocked. As evident from the data in this study, inadequately resourced institutions serve no purpose except to become a "dumping ground" for those elderly persons who have health problems for which healthcare interventions are not readily available (e.g. dementia) or who are awaiting assessment in an effort to determine the best health care outcome. The key objective for hospital staff was to maintain throughput, whilst the key objective of rehabilitation staff was, as Eldar (1999) points out,

> *"...an understanding of rehabilitation goals and processes and establishment of valid criteria and standards that specify an adequate, acceptable or optimal level of quality of rehabilitation care".*

Roe, Daly, Shenton and Lochhead (2003) also endorse this, claiming that criteria need to be tightened up to avoid overlap. Some efforts have been made to coordinate activities in rehabilitative care. However, Cameron, Handoll et al`s (2004) review of randomised trials of persons with femoral fractures undergoing coordinated multidisciplinary rehabilitation found no statistically significant differences between this approach and standard orthopaedic care. Moreover, there seems to be no consensus on the best way to manage post-hospital care for selected patient groups between early supported discharge (ESD), hospital at home (HaH) (Shepperd and Lliffe, 2004), conventional rehabilitation (Beech, Rudd, Tilling and Wolfe, 1999; Cotton, Bucknall and Dagg, 2000) and Advanced Nurse Practitioner home follow-up (Naylor, Brooten, Campbell et al, 1999; Phillips, Wright et al, 2004) although the latter three studies found positive outcomes for patients. Although stroke survivors enjoyed reduced lengths of stay with an ESD scheme (Cochrane Library, 2004; Legg and Langhorne, 2004) and nursing led inpatient units (NLU) were found to prepare patients better for discharge (Griffiths, Edwards et al, 2004), they suggest more research is needed, conclusions reached also by Jarlier and Charvet-Protat (2000). Macintyre, Ruth and Ansari (2002) found that Hospital in the Home (HITH) did reduce crude costs but that many other factors other than the location of care can influence crude costs as did Weissman (2001). As an example, Oterino-De-La-Fuente, Piero, Ridao and Marchan (1998) highlight the higher costs incurred by differing diagnostic and therapeutic patterns in acute care compared to other forms of care whose locus is in the home.

Griffiths (2002) suggests that the real issue is one of skill mix since, if skill mix is poor, no benefit will be derived from NLUs. By extension, therefore, it seems that whatever intervention is decided upon it must be adequately resourced.

All schemes to remove patients from hospital early but with support require further investigation in terms of clinical outcome and cost since the only degree of consensus that currently exists appears to be that patients would prefer to be treated

in their own home (see Corwin, Toop, McGeoch et al, 2004). Grimmer and Moss (2001) note, however, that quality of life among post-hospitalised patients decreases at one week post-discharge and it is, therefore, imperative that some method of allowing people to adjust to new life situations in the community is found (see also LeClerc, Wells, Craig and Wilson, 2002, Adams, 2003).

One patient who had been discharged from an acute hospital during the course of this study had a number of unmet needs following discharge. The person remained in pain and could not wash or dress himself without assistance from his carer, he also had problems which, although separate from the primary presenting symptom and reason for his admission, should still have been investigated whilst this person was in hospital. His carer was tired and agreed that some more help during the post-discharge period would have been welcome. The patient and carer could not agree, however, on whether care was necessary. Indeed, a salient feature of this study was the difference in knowledge and expectation between health care professionals, patients and their carers. The more experienced professionals who were in contact with patients in the community opined that many patients and/or carers left hospital with unrealistic expectations concerning their ability to cope at home. Furthermore, there was disagreement between carers and patients regarding the best way to proceed concerning discharge and the level of input that would be required thereafter. This is supported by the work of Rudd and Smith (2002) who acknowledge that patients changing their minds could impede early discharge planning. Pearson, Proctor et al (2004) noted in this regard that:

> *"Patients and carers were constantly negotiating their social roles, seeking to juggle appropriate identities and limited resources to maintain their own and each others` dignity and quality of life. When the negotiation process was destabilised...then either or both parties sought a way out. In all the cases examined the result was admission to hospital – usually, but not always, mediated by community professionals"*

It was found that, in the study reported here, both health professionals and patients and their carers attempted to negotiate favourable outcomes in order to minimise workload or to ensure a better quality of life. Such informal negotiation caused resentment amongst all sections of people involved in the discharge planning

process. Plainly, negotiation plays an important part in the discharge planning process in ensuring that all individuals' needs and expectations are met as fully as possible (including the needs of the professionals involved). Such negotiation was found, however, to be destructive when it occurred on an informal basis without the needs of other parties being taken into account. Formalisation of the various phases of the discharge planning process would allow needs and expectations to be explored at the very beginning of a persons stay in hospital and not immediately before departure when such expectations become clouded by shortness of both time and resources and where ineffective communication is likely to occur more often. In this regard, Annells, Koch and Brown (2001) have developed a Client Generated Index tool which may allow hospital and community staff alike to place patients and carers in a position by which they are involved in setting goals, assessing and planning for their own discharge.

5.4: Fragmentation of service delivery.

Fragmentation of service delivery was noted during both phases of the study. Its most obvious effect was to disrupt the flow of information in the discharge planning process. What was found in both phases of the study was that nurses in particular were concerned about the fragmentation of care as it directly affected them. Also, many specialist nurses were actively seeking out new referrals in ward areas but the nursing staff were unsure who had referred them or why. It occurred because of the number of persons involved in all stages of the discharge planning process and was also found to be exacerbated by the practice of outlying patients and current nurse handover practices. It appears that, in order to ensure the rigour of discharge planning, the process is being compartmentalised into a number of smaller tasks. Thus, rather than training generalists with the requisite knowledge to appreciate the complexities of health care processes overall, the current emphasis is on the training of specialists with a narrower focus. This affects the discharge process because of the increase in duplicate documentation. Nurses at both Trusts commented that it was now necessary to complete the same documentation for different specialities (for example pressure sore and nutritional assessment tools). This caused nurses to spend less time with patients and continues the process by means of which the locus of control is moved away from nurses but without

anything else replacing it. Trust B, as an example of the increase in personnel, have appointed a care coordinator whose job it is to access notes and reports for the ward rounds. The theory behind this is that it would relieve some pressure from the nursing staff but instead it has left them feeling threatened and confused as the information necessary to conduct a ward round and manage a ward has been removed from them. At Trust A concerns were also voiced about fragmentation. Many nurses felt that the specialist nurses were again picking and choosing and becoming involved before it was necessary. Even among discharge liaison nurses who were rated highly by the ward nurses of Trust A there was felt to be inconsistent working patterns and delegation of tasks to the ward nurses as well as duplication of requests for information and idealism in patient management.

This also occurred during the practice of outlying patients to other wards. During such periods duplication was common which was due to poor handover between wards necessitating the recommencement of the discharge planning process and the need to recheck whether certain referrals had been made to the relevant services. Access to services on weekends and holidays were seen as a particular problem with all specialist nurses.

Kossovsky, Chopard, Bolla et al (2003) noted that inefficiencies occurred because of the number of persons involved in particular phases of the discharge planning process whereby information was transmitted to (in this case) five persons on a number of occasions. Following modification of the process, the number of involved persons was reduced and information was transmitted only once. Reed, Veith, Nicholas et al (2004) documented the appointment of a length of stay (LOS) officer who significantly reduced hospital stays in those patients undergoing vascular surgery. This is an example of the manner in which care delivery will be fragmented since this LOS officer would be duplicating the efforts of all other staff who are engaged in reduction of lengths of stay as a secondary objective, the primary objective being good discharge planning. It would appear that, in the rush towards efficiency, it is tempting to examine just one or two of many variables. To do this, however, is to ignore the complex working patterns between consumers, carers and the various providers, which have built up over time.

5.5: Workload, morale and standards of care amongst district nurses and acute nurses.

Shortage of staff was identified as a problem during both phases of the data collection period. Shortages of staff affected social work, nursing, and occupational therapy in both community and acute settings. Indeed, the shortage of practitioners meant, in some cases that referral criteria had to be reassessed and made more stringent in the case of occupational therapy, whilst in the case of other departments (such as district nursing) an attempt was made to cut down on inappropriate referrals (21%) from the acute care setting. Bowles, Foust and Naylor (2004) identified workload and staffing as being highly influential in the discharge planning process. They assert that there is a lack of time to conduct thorough and ongoing assessments or to communicate effectively.

The differing responses to occupational pressures between community and acute staff were also interesting. Ward-based nurses in Trust A and Trust B were more resistant to change than their community counterparts. The exceptions to this were the paediatric ward staff who appeared to be attempting to embrace new and more inclusive working patterns in order to provide more patient-centred care. Many general nurses were guarded in their response to change, seeing it as the community nurses` responsibility to "inreach" to the hospital rather than hospital nurses providing some form of "outreach" service. By contrast, there was some evidence of role interchange between community nurses and social workers in the provision of patient services. This is occurring despite the fact that community and acute nurses face exactly the same pressures of employment. This is supported by the work of Evans (2002) who examined stress amongst district nurses. She found that there was an imbalance between staffing and workload, no time to adjust to change, and poor interagency relationships. Other manifestations of low morale proportional to a perceived high workload were found among nurses who noted that relatives were becoming increasingly hostile towards them. This hostility resulted from cancelled operations (a management issue over which, nurses argued, they had little control) and also because nurses were perceived as preventing patients from leaving hospital because assessments by other agencies raised safety concerns. Nurses` morale was lowered, therefore, when they perceived themselves to be

caught between the competing demands of other agencies, between patients and carers and between doctors and discharge planners.

5.6: Issues of role.

In both phases of the study reported here, issues of role were noted frequently. There appeared to be a polarity concerning the role of the various professionals in the discharge planning process. Junior staff struggled to define their role within this process and described a paucity of knowledge in this area. Concerns were raised that much of the knowledge required was gained through experience and was, therefore, unsystematically acquired. More experienced nurses felt that they had the required level of knowledge (although their perception of what constituted the required level was minimal) but that the number of specialist nurses currently involved meant that either they could not exercise their perceived role to the desired level or that they did not need to exercise any knowledge in this area because they could refer on to these more experienced personnel.

Nurses also claimed that, on occasions, their professional judgement was called into question by some specialist nurses and that some specialist nurses appeared to be overstepping traditional role boundaries in generating their own referrals and in doing so, by-passing ward-based nurses. The teaching role of specialist nurses was widely adjudged to have been sacrificed to the needs of increasing caseloads. There were misconceptions of the true nature of professional roles between managers and nurses and between nurses and other professionals such as specialist nurses, social workers and occupational therapists.

Of particular concern amongst some nurses was the widening role of the Health Care Assistant (HCA). Many nurses felt that HCAs were ill-prepared to assume some of the responsibilities of what was viewed as the traditional nurse role which led to a worsening of care standards. Nurses claimed that although HCAs were poorly trained, they were, of necessity, encouraged to take on certain aspects of the nursing role and yet nursing staff remained responsible and accountable for any mistakes that were made. If this trend towards increasing inclusion of HCAs is to continue, it is imperative that the largely physical nature of this role is

supplemented by a theoretical underpinning, which should include methods of discharge planning and anatomy and physiology. Also, junior nurses and experienced nurses alike should be taught the rudiments of leadership and delegation to ensure standards of care are maintained for, as Chaboyer, Foster et al (2002) assert, the importance of having a highly visible individual who should take overall responsibility for the planning of a discharge is of supreme importance.

Chaboyer, Foster et al (2002) also found that the number of healthcare professionals actively involved in discharge planning at any time was confusing to patients and professionals alike. Often, roles of various staff intersected causing duplication, inappropriate referrals and resentment among ward staff who felt that they were being deskilled or that their professional judgement was being challenged. Moreover, Marramba, Richards and Larrabee (2003) found a variety of discharge planning practices in which varying professionals assumed the role of discharge planning coordinators but claimed that insufficient evidence was found to justify a change from the practice of the staff nurse assuming this role despite findings from Jolly, Bradley, Sharp et al (1998) which suggested that the role of a liaison nurse is effective in the follow-up care of patients who have suffered a myocardial infarction or angina or those patients suffering from heart failure (Phillips, Wright et al, 2004).

The difficulty in clarifying the role of hospital staff involved in the discharge planning process lies in the fact that many roles are seen to overlap and are not understood by others. Pethybridge (2004) notes, for example, that, in the context of relationships between doctors and nurses, there was little understanding of each other's roles and little shared learning or crossing of boundaries. Wright (2002), in examining the role of the district nurse asserts that the role is poorly understood by the majority of other health care professionals and indeed by the district nurses themselves (see also Wilson, Pateman, Beaver and Luker, 2002 and Goodman, 2000). McKenna, Keeney et al (2000) noted that in a sample of district nurses 38.6% saw their main role as organising equipment. Wright herself lists the components of the role as being the provision of physical, informational, emotional and social support. Even if one was to be more specific about the principal components of this role, it would be difficult to assert that it differs from any other

nursing role or indeed the role of the social worker. It may be that protestations concerning the uniqueness and indispensability of individual roles serve to merely entrench more deeply boundary issues within health.

5.7: Lack of knowledge.

A sound knowledge base emerged as important in the findings of phase I of the study in relation the assessment of patient needs, correct referral mechanisms and the arrangement of services in the post-discharge period. Nurses were not being taught to assess the needs of patients, whilst junior staff in particular found themselves having to arrange discharges with minimal support. The rudiments of the discharge planning process were learnt in the clinical area without any theoretical underpinnings. This misunderstanding of the system by which vulnerable adults are discharged from hospital was exacerbated by a lack of knowledge of hospital policies. Whilst the majority of ward managers claimed that they regularly read organisational policies, the majority of the more junior staff claimed that they did not have time to read policies. Thus this important source of knowledge was neglected. In defence of nurses, however, it must be pointed out that organisational policies and directives from the Department of Health make it very difficult to keep oneself informed of the many changes during a period of great flux.

Knowledge gained from keeping up to date is important to patient care, however, as Atwal (2002) found considerable evidence to suggest that the expertise of individual practitioners influences patient management. This is supported by the work of Bowles, Foust and Naylor (2003) who found that lack of knowledge of referral methods was a key determinant in whether or not patients were referred to appropriate services. Carnwell, Helm and Werrett (2001) assert that this lack of educational provision in the field of transitional care occurs despite the fact that nursing staff have strong convictions concerning the contents of such a curriculum. Carnwell and Daly (2003) also found that respondents in their study agreed that knowledge must be shared.

Nazarko (1998) claims that the role of the discharge coordinator is to act as a

"counterweight" to those forces that are likely to fragment care, enabling the delivery of holistic patient centred care. Findings from this thesis indicate, however, that the number of professionals involved in patient care serves to fragment care. The role of the discharge coordinator as counterweight is not being fulfilled in its entirety. Part of the role should be to ensure that nurses are equipped with the requisite knowledge to be able to ensure continuity of care in the discharge planning process but at no time during the data collection period at Trust A were discharge planners (or indeed any staff involved in the discharge planning process) seen to actively teach ward-based colleagues. Of course workload pressure and time constraints are not conducive to the dissemination of knowledge but, nonetheless, such dissemination is an important part of the role of the health care professional.

Robinson and Street (2003) found that nurses received little feedback on the effectiveness of discharge planning and note with concern that this will lead to a promulgation of current sub optimal practice such as poor initial assessment. This, in turn, will lead to the missing of important information. This lack of knowledge amongst ward-based nurses is explored further by Robinson and Street (2002) who note that ward nurses were extremely negative about the particular intervention which formed the cornerstone of their study, that problems with assessment and discharge were made worse because the nurses assumed that the senior nurse would take responsibility and that any discharge problems would be picked up in the community. Robinson and Street (2002) note also that the ward nurses mediator of action was "obviously something that was historical, they were used to doing it". Further, the same respondent added "I was really surprised at their lack of knowledge. I assumed they had a greater knowledge than they did and I was continually astounded as to how ill-informed they were".

5.8: Relationships between professionals.

The data from phase I and II of the study revealed the importance of relationships between professionals. In particular it emerged that although nurses in this study expressed displeasure using language that was patient centered, displeasure was evident nonetheless. Relationships between nurses and patients were mediated to a

degree by the characteristics of the patient concerned (Bowles, Foust and Naylor, 2004). Whilst they found that patients with chronic conditions, or those patients who were classed as difficult or demanding, where less likely to be referred to appropriate services such as skilled home care, in this study referrals appeared to be missed due to time constraints or genuine oversight.

Displeasure of the nursing staff could be incurred because patients were too demanding, because they had been admitted or placed inappropriately, or because they were claiming services which nurses felt were unwarranted. It was evident that, although both nurses and patients engaged in the ritual of mutual satisfaction, this was not always the case when specific aspects of discharge planning were examined. Since the maintenance of relationships with all parties is of vital importance in the discharge planning process, some thought should be given to the use of patient contracts, which can be used by patients, nurses and carers to formulate a realistic discharge plan with realistic goals, expectations and entitlements.

One of the most surprising findings during both phases of the study was the importance of regular face-to-face contact between all members of staff involved in the discharge planning process. Ward nurses in particular seemed to grade the various staff who visited the wards. Staff were graded according to their degree of visibility on the wards, the degree to which they were felt to be approachable and the degree to which they let the ward staff know of their intentions. This is very closely related to communication and documentation (see below) since part of the essence of what nurses perceived as being approachable consisted in not only talking to the ward staff but helping them and, more importantly, documenting interventions in the notes to enable the ward nurses to act on or be aware of decisions that had been made regarding the care of their patients. It is also interesting to note that whilst newly qualified staff felt that they had been given little support in arranging discharges and felt that they did not know enough about it, their more senior colleagues argued that they knew enough and would rather that the discharge planner or social worker made arrangements thus decreasing their workload.

Recent literature suggests that patient and carer involvement in the discharge planning process could be enhanced by increasing patient and carer participation in case conferences. Although this did not emerge in the findings of the study reported here, it has been noted in a study by Efraimson, Hyden et al (2004) who examined patient participation in case conferences. They noted that participation was minimal and that many decisions had already been made. They concluded that institutional representatives both encouraged and repressed patient participation in an attempt to both satisfy the caring ideal and to meet the demands of the organisation and that "[institutional representatives] and patients were equally imprisoned within the institutional system…This result illustrates how conflicting paradigms are embedded and reproduced by healthcare professionals in their communicative praxis".

5.9: The Doctors' role in discharge planning.

Findings from both phases of this study indicate that doctors are key players in the discharge planning process. It was subsequently discovered, however, that doctors, for various reasons, have a very limited role in the planning and expediting of discharges. Weinberg and Stason (1998) also note that decision making by medical staff has a key role to play in achieving the desired quality outcomes but that few doctors routinely audit these decision trails. Weinberg and Stason`s (1998) study illustrates perfectly the fact that correct use of resources is the key to an effective model of discharge planning and that effective discharge planning begins on admission (Chaboyer, Foster et al, 2002). They found that six percent of all admissions contained "quality problems". They noted further that:

> *"Of these, 60% were missed or delayed diagnoses, 22% were iatrogenic complications and 18% were inappropriate treatments. Root cause analysis suggested that physician behaviours led to 75% of problems; systems problems to 20% and inadequate knowledge to five percent."*

The importance of the physician in proactive discharge planning cannot be over emphasised and yet in both Trusts from which information was collected doctors were found not to be influential in the main in the area of discharge planning.

Medical consultants were proactive in attending multidisciplinary team meetings but more recently qualified doctors and members of the surgical speciality appeared to remain sharply focused on the immediate presenting condition and to leave the bulk of discharge planning to nursing staff and social workers. This is supported by findings of Bowles, Foust and Naylor (2004) and Chaboyer, Foster et al (2002) who found that 67.2% of ICU nurses surveyed felt that medical staff did not provide enough direction for them to be able to plan discharges. Pethybridge (2004) questions whether doctors are in fact the best people to lead the discharge planning process, citing little clinical input and, therefore, little control.

Doctors also emerged in phase I of this study as being responsible for some rise in inappropriate admission numbers because junior medical staff decided to admit patients rather than discharging them. This is supported by Kossovsky, Chopard, Bolla et al's (2003) study which states that a significant amount of inappropriate bed use was caused by referrals which evaded the triage process, in particular those patients sent to hospital by community physicians. Other causes of inappropriate admission were found by Pickard, Bulbeck and Woolmore (2004), who highlighted a series of inappropriate admissions and long waits in A&E resulting from referrals by community services, inappropriate tests and poor coordination between services. This was evident in both phases of data collection for the study reported here and the inappropriate referral of patients needs to be addressed. Kossovsky, Chopard, Bolla et al (2003) established a telephone service for GPs which allowed the sharing of information thereby avoiding the need for hospital admission whilst Moya-Ruiz, Peiro and Meneu (2004) claim that providing feedback to physicians significantly reduced inappropriate stays attributable to the doctor.

5.10: Community and acute nurses' role in discharge planning.

Throughout the period of data collection it was evident that there were key barriers which, nurses argued, inhibited effective discharge planning. These were time, lack of knowledge, lack of resources and paperwork. Chaboyer, Foster et al (2002) found that 40% of ICU nurse interviewed perceived that they lacked knowledge in the area of discharge planning whilst most nurses argued that discharge planning was time consuming (55.2%) and that the levels of paperwork would increase as a

result (64.3%). Two other findings are pertinent to this discussion. Over 56% of ICU nurses reported that discharge planning should not be the responsibility of the ward nursing staff and 41.4% indicated that rapid changes in the condition of patients limits the usefulness of discharge planning in intensive nursing settings. This uncertainty of outcome is not, however, the sole province of the ICU. Many of the nurses interviewed felt that the patients` condition limited the time available to plan discharge effectively. If too much time was spent attempting to sort out all arrangements then the window of opportunity would be missed. Some nurses stated that patients had been discharged inappropriately, whilst other Clinical Nurse Specialists recounted experiences of patients not being referred to the relevant services by nursing staff as this would impede discharge. There is a dichotomy here in that although some discharges and subsequent readmissions are doubtless due to what Jimenez, Lopez et al (1999) term "inefficiencies of care", some may also be due to the fact that, as they point out, there is no agreed definition concerning the length of time a person should be in hospital. What is certain is that in order to combat obvious deficiencies in service provision by nurses, more education and support must be given so that nurses can effectively carry out those interventions the value of which is well recognised by the nurses themselves (Chaboyer, Foster et al, 2002).

5.11: Social workers' role in discharge planning.

In both phases of the study (but particularly during data collection in phase 1\Trust A) social workers were seen to bear the brunt of nurses` and doctors` dissatisfaction with the discharge planning process in the guise of throughput. No other group was so unfairly maligned. The reasons for this were both complex and surprising. The reasons for staff dissatisfaction with this occupational group included the time it took to have a patient allocated and assessed, the fact that few social workers were seen on the wards, that they did not document information properly and that notes concerning referral were lost which necessitated re-referral. The finding of hostility amongst nurses towards social workers was surprising because nurses and social workers operated under identical constraints in terms of time and resources. Furthermore, nurses engaged in exactly the same practice as they allege against social workers in that nurses failed to provide adequate documentation to allow full

assessment to occur and frequently did not transmit information effectively. Staffing levels were generally the same and yet social workers were a good deal less outspoken in their criticism of nurses than vice versa.

Throughout the study it was noted that social workers and other healthcare professionals used meetings to engage and attempt to withdraw from commitments in the face of decreased resources and competing demands. Social workers did, however, have the highest rates of referral in Bowles, Foust and Naylor's (2004) study, linked perhaps to their greater knowledge of available resources and how to access them. Holliman et al (2003) note that the core tasks carried out by nurses and social workers are strikingly similar in terms of providing information, assessing and coordinating services. The differences were also important – nurses were concerned primarily with the completion of physical tasks whilst social workers were more concerned with patient advocacy and the resolution of mental health problems. Holliman et al (2003) add that because physical work appeared to be more valued by hospitals, hostility arose. They conclude, however, that social workers have a key role to play in the discharge planning process, a conclusion that was supported entirely by data from the study reported here.

5.12: Communication in the discharge planning process.

Communication arose in both phases of this study as one of the most important facets in improving discharge planning. Many nurses made comparisons between earlier practice and current practice. In the former case the nurse was pivotal to the discharge planning process, acting as a fulcrum of communication between both professionals and patients – all information flowed through the ward manager or team leader. Now, however, nurses were unsure of "just how far we've got with a patient" and whereas previously information could be easily recalled, nurses were finding that they had to make an effort to go and find out.

The number of types of communication found during the course of the study were many but, for the purposes of clarity, may be classified as follows; communication which occurred in the nurse handover, communication which occurred between nurses and other professionals, and communication between professionals and

patients and/or carers.

One of the chief complaints voiced by nursing staff was the lack of communication between themselves and members of other disciplines. Other professionals (most notably social workers) argued, however, that the situation was made worse because nurses failed to communicate effectively with their colleagues during the nurse handover. It was evident (particularly at Trust A) that a person's progression through the various stages of the health care system was not given sufficient emphasis (by nurses) other than as a series of observations concerning the progression of the disease. Detailed communication of a person's psychosocial history was never observed, nurses instead preferring to use dominant biomedical taxonomies (Hardey, Payne and Coleman, 2000).

Communication through documentation was seen as primarily there to deflect blame and to avoid litigation. Comments included the fact that nurses are not taught to discriminate between differing types of information and judge its importance accordingly. This has consequences for the assessment of patients since it means that junior nurses are not being provided with guidance on how to assess and are documenting details that are seen as background information. The need to use documentation as a method of avoiding blame also means that the amount of duplication is increased leading to a greater likelihood of mistakes in the process of communication. Communication is further hampered between nurses, patients and their carers because the need to provide exhaustive documentation concerning nursing practice takes nurses away from the bedside. Fear of litigation also imposes a degree of psychological as well as geographical distance between nurses and patients, a distance, which places further strains on the communicative process and makes poor discharge more likely to occur.

One of the key areas in the communicative process was nursing documentation. This was generally found to be of a poor standard, uninformative (Nazarko, 1998) and did not allow correct storage and transmission of information in order to improve continuity of care. Currell and Urquhart (2004) reviewed existing literature in an attempt to establish a relationship between nursing practice and health care outcomes. They found no evidence of improved outcomes attributable

to changes in nurse record keeping but suggested more research is needed in this area. Hardey, Payne and Coleman (2000), however, found that scraps of paper used in nurse handover were significant in facilitating nursing care and that this should be recognised in nurse education programmes.

Findings from the study reported here indicate that the system currently predominant is such that nurses use scraps to attempt to ensure the transmission of information. Continuity of care is, therefore, less than optimal and the truth probably lies somewhere between the two views expressed above. Scraps and the way the nurse handover is carried out are significant mediators of care standards and continuity. The use of scraps and the predominant emphasis amongst nurses on the biomedical care model is likely to significantly impede the flow of information generally and the flow of information concerning psychosocial elements in particular. This is particularly the case given the level of care fragmentation as more and more discrete professions become involved in the discharge planning process.

The findings from the study reported here indicate that, at least in the initial formative stages, some method of formalising nurse handover may pay dividends in ensuring that all relevant aspects of a patient's circumstances are discussed, assessed and passed on to other professionals involved in the care of that individual. Lichtenberg et al (2004) note that interdisciplinary assessments (*including psychological measures*) [italics mine] provide valuable data for effective discharge planning and that, furthermore, such data is an accurate predictor of "successful long-term adjustment. These findings are entirely supported by McKenna et al (2000) who note that the discharge planning process must be formalised, that clarification and education of staff regarding roles must occur and that there is currently a lack of quality communication between community and acute providers.

Ashburn, Murphy Payne and Wiles (2004) and Proctor, Wilcockson, Pearson and Allgar (2001) further note that in order to manage patients` expectations immediately pre-discharge it is vital that communication is effective in allowing engagement between patients, their carers and health care personnel. Findings

regarding poor communication between patients, carers and acute and community providers involved in the discharge planning process are supported by Johnson, Sandford and Tyndall (2004), McKenna Keeney et al (2000) and Rose, Bowman and Kresevic (2000), Driscoll (2000), Hancock, Chan et al (2003), Cleary, Horsfall and Hunt (2003), Rentsch, Luthy, Perneger and Allaz (2002), Fallowfield (2002), Jenkins, Fallowfield and Saul (2001), Evans (2004), Tyson and Turner (1999 a and b) and MacLachlan (2004). McKenna and Keeney et al (2000) note wide discrepancies in the views of community and hospital nurses in key areas of the discharge planning process. In key areas of communication there was a lack of agreement between these two occupational groups concerning whether referrals to correct agencies were made and whether contact numbers of community staff were given to patients. Sixty-eight percent of district nurses found communication unsatisfactory. McKenna and Keeney et al note that "this shows that in an integrated hospital and community Trust the very basis of discharge planning – communication and provision of information – are problematic." Moreover, Wright, Jolly, Spellar and Smith (1999) found that the lack of discharge notification from hospital was the principal reason why practice nurses discontinued follow up care.

Of referrals, Bowles, Foust and Naylor (2003) assert that it is important to understand what information should be contained in a referral in order to avoid adverse outcomes and they note that poor planning and communication contributes to the phenomenon of ill-planned Friday or weekend discharges. They note that the gathering of information is not approached systematically which means that not all relevant information is collected particularly concerning psychosocial issues and those of the home environment. A finding of the study reported here was that nurses did not approach referrals systematically either, tending to action blanket referrals "just in case" (see Roe, Day, Shenton and Lochhead, 2003). To nursing staff it meant simply the completion of a small form, but to intermediate care staff and district nurses the consequences of this were wasted time and duplication of services, or patients receiving no services at all. This was especially true in nurse liaison with social services staff who frequently reported that they had received referrals from patients only to find the patient had already been discharged (although ward staff maintain that this is because response times are slow – borne

out by findings from the study). Whilst acknowledging the fact that, in order to gain most from rehabilitative services, a person must be suitable, this does leave unanswered the question voiced by one nurse in particular of just what is to be done with those people who are heavily dependent or who have mental health problems?

5.13: Summary.

Findings from the study reported here indicate, in summary, that both Trusts were subject to both internal and external pressures due to an increasingly aged population and health care policies which have become increasingly restrictive due to an increased financial orientation. The system was placed under further strain due to the division of labour into a series of specialist tasks and the consequent influx of specialists which caused a shift in the locus of control manifested in misunderstandings of role, poor knowledge base and, therefore, poor communication, assessment, implementation and little attempt to evaluate interventions. Local relationships, a vital part of successful team working, were put in jeopardy as individuals allow sectional interests to predominate.

The method by which integration of all professionals involved in the discharge planning process is to be achieved is therefore clear. In-depth knowledge of the aged care system must be a prerequisite to enable nurses and indeed all professionals to take an active role in providing robust, evidence-based discharge arrangements. The findings of this study indicate that initiatives, relationships and collaborative networks develop (to concur with Robinson and Street, 2004) at a local level and that such networks are based upon friendship, trust, experience and reputation. These relationships are extremely important since they are most immediate and accessible to the patient and their carer and, therefore, these types of relationships, properly developed, will allow empowerment of the patient and carer. Indeed, if these relationships are simply left to develop in an ad-hoc manner or, more correctly, if no attention is paid to their development, then lack of knowledge, lack of understanding of the roles of the various personnel involved and lack of time will ensure that negative stereotypes will continue to abound and that lack of formalised guidelines will mean that staff, patients and carers will continue to manipulate the system to achieve desired outcomes based on narrow sectional

interests.

Pethybridge (2004), in support of these conclusions, found that strong leadership was a key attribute in this respect and was, therefore, vital in the discharge planning process. What is needed, therefore, is a method whereby the many aspects of the discharge planning process may be formalised, not in order to stifle creativity and flexibility which are themselves important attributes within an organisation which must constantly adapt to new demands, but to ensure that cognisance of the intricacies of the aged care system is guided away from maladaptive strategies and in order that rigorous practice may emerge. Dissemination of knowledge is crucial in this regard and includes any strategy which enables the individual to step outside traditional role boundaries and mundane working environments to look at the discharge planning process in all its intricacies from a number of different, new and exciting perspectives (Allen, Lyne and Griffiths, 2002). That, after all, was the principal personal finding of this study. The practical implementation of such strategies are suggested in the following final chapter.

Chapter 6: Conclusions and recommendations for practice..

This chapter contains a discussion of the principal findings of this thesis. All Trusts examined were similar demographically, being composed of an increasingly old and frail population, which made specific demands on the health care system within these communities. All demands take place within the context of the need to treat more dependent patients in a manner which safeguards throughput thereby maximising appropriate bed utilisation when bed capacity is already stretched and crises occur routinely.

To conclude, the research questions posed at the outset were:

1. Are there differing perceptions amongst health care professionals regarding the role of other health care workers?
2. If different perceptions do exist, how are they formed and how do they become current?
3. Does this affect communication, particularly within the discharge planning process?
4. Finally, how do perceptions held by health care professionals affect the manner of service provision to service users?

Question One.

That there are differing perceptions of other health workers is clear. The members of broadly related occupational groups relate to one another to a greater degree than those who are seen as either outsiders or who are seen as providing an ineffectual service. The bond between, for example, nursing related disciplines enables conflict to be more effectively managed by drawing on shared knowledge, language and experience – a shared reality. Social workers, by contrast are seen as ineffectual as a whole and are also outsiders, their patterns of socialisation are different when compared to the vast majority of hospital staff and may lack the imperative of nurses` socialisation, which is partly forged through organisational demands and definite geographical location.

Question Two.

Such perceptions, which emanate from socialisation remain current through confirmatory experience and the high regard in which nurses are held by patients. Both nurses and patients connive to maintain their inter-related perceptions of one another, which further increases the nurses` standing. The nurses` perversion of the caring discourse allows them to promote group cohesion whilst avoiding dissonance which organisational demands create. The patients' recognition of the nurse as a professional and the recognition that there are tacit rules to be followed further strengthens and maintains the influence of socialisation. The internal validity of such perceptions, that is, the validity which such perceptions possess for members of the occupational group concerned, are reinforced by perceived negative experiences. Eventually, a point is reached where further negative encounters elicit further condemnation and unexpectedly positive experiences elicit not praise, but surprise or, more commonly, simple acknowledgement that this should be happening all the time, its part of their job.

Question Three.

This has obvious effects upon communication within the discharge planning process, effects outlined in the discussion above. There are also numerous effects upon the service user. Although patients recognise the presence of rules within the ward environment and although they attempt to obey these rules, they are unsure of the information they are required to give and when, if at all, they are required to give it. Thus there is an interstice between nurses and patients and this is increased if patients are delayed or seen as demanding or undeserving since this decreases the likelihood that nurses will communicate effectively with certain patients and increases the probability of patients becoming withdrawn, uncommunicative and failing to obtain information which they need on discharge.

Question Four.

Thus, certain maladaptive characteristics may be present in persons as members of discrete organisational groups. These characteristics are most apparent during times of increased uncertainty and increased workload. During these periods as boundaries

become more impermeable and the distance between them increases, playing the system also increases and communication is likely to become poorer as a result. That is, as the interstices between cells increase the harder it becomes to achieve unification. This thesis suggests that some problems are amenable to fairly simple solutions, the cutting down of paperwork in order to allow senior experienced staff on the ward for example, or the use of patient contracts.

Other problems are, however, less amenable to simple solution and this lies in part in the way in which discharge planning is described. It is generally described by using the word "seamless" (or any one of a number of synonyms), which denotes a smooth progression through phases until the desired endpoint is reached. During the fieldwork for this thesis, however, it became apparent that borrowing descriptives from the world of hosiery did the concept of discharge planning no service at all since the term "seamless" is suggests that little effort is required because everything is arranged within broad policies and eventually everything will be sorted out, in the background perhaps, but sorted out. This is to miss a fundamental point about the discharge planning process. Although the overall aim is to provide seamless care, seamlessness is a quality that is arrived at through the management of discrete stages in health care delivery; each stage must be successfully ended before the next stage can be embarked upon. It is unlikely, however, that the term "stroboscopic care" will gain wide currency despite this capturing more adequately the nature of the discharge planning process. With this in mind, however, if one accepts that there are mutually exclusive but interdependent stages within the discharge planning process, it should be possible to devise descriptive scenarios for each stage of the process in order to anticipate each eventuality. Rather than viewing it as one process and having one huge policy (as is the case in all Trusts studied) deconstruct it so that the relationships and pitfalls become more apparent, so that all roles of individuals become clearer.

6.1: Substantive conclusions.

Health care organisations are founded upon the need for syncretism, that is, the organisation develops responses quickly in order to meet newly emergent demands of the patient population it serves. This poses unique problems. Those more commercially orientated concerns have a built in system of checks and balances

because of the sequential nature of their endeavours. Such sequential ordering of organisational operation may be expressed as A then B then C. Within health care, however, A, B and C are likely to be happening concurrently. This gives rise to many of the problems of communication since it means that the amount of time that an operative has to complete tasks and inform all other relevant agencies is telescoped. Whilst this offers advantages to organisations in terms of speed of response and adaptability, that responsiveness and flexibility limits the ability of an organisation to enumerate and formalise the equally important sequential steps which must be taken in the provision of good discharge planning arrangements. Whilst the Trusts studied were attempting to improve communication channels, this was carried out within already extant operating arrangements. It is recommended that more research should be carried out into the relationship between syncretism and sequentialism as the foundation of good communication policy. This may enable the deconstruction of tasks and the realisation of when sequentialism or syncretism offers the greatest advantage and at which times.

Although the language used by occupational groups within the health care setting has been recognised as inherently disempowering to service users, little research has been carried out into the manner in which both nurses and relatives attempt to ensure favourable outcomes by playing the system. Further investigation should be undertaken into the manner in which the interface between language use of patients, relatives and health care staff can lead to unfavourable outcomes on both sides as agendas are masked by a language use which serves to maintain the image of the professional and which is adhered to by service users and service providers alike. Maintaining the image of the professional itself constitutes a language game, an attempt to ensure favourable outcomes for all concerned.

Finally, there is a pressing need to undertake further research into the use of nursing models and care pathways as mediators of nursing assessment skills. Ongoing assessment is fundamental in determining the quality of care individuals receive throughout the stages of their illness and yet it was found to be of a uniformly poor quality. Further research should include the influences of time, nursing models, care pathways and the presence of senior, experienced staff or clinical educators in the ward area. Even when an assessment is carried out, there is evidence to suggest that

information is missed at the interface between the assessor and the service user because of differing interpretations based on differing concepts of illness (i.e. folk versus professional).

Further research should have the principal aim of examining dynamics within occupational groups so that commonalities may be found to enable cross-boundary working to occur more readily. Much is made of cross-boundary working at the interface but cross-boundary working may be facilitated by defining conceptual blocks, particular aspects of socialisation, particular taboos held by members of groups, which mean that the requisite collaborative outlook is stunted. Professionals as members of groups must be encouraged to look inwards before outward looking initiatives will be successful.

The following section contains those recommendations that can be implemented at all levels of the organisation.

6.2: Limitations of the study.

The limitations of the study are the lack of a quantitative dimension within the study. It was initially envisaged that triangulation would occur between the different paradigms and a Likert Scale was devised to assess nurses` attitudes to aspects of the discharge planning process. Despite being distributed across two hospital sites, the response rate was too low to enable sufficiently reliable analysis to occur. Although interesting concepts concerning nurses` orientation to the discharge planning process in general and to other staff in particular were suggested, more research is needed in this area.

Secondly, it has been suggested that, throughout the study, social workers are seen to be at fault for the shortcomings of the discharge planning process within the participating Trusts. This has never been intentionally suggested and the author did attempt to provide balance and write in a sensitive manner. The relative disproportion of nurses and social workers within the sample sets may mean, however, that there is a bias in this area. The point remains, nonetheless, that there *was* a perception that social workers were the "bad guys" and as such this remains a genuine and important finding in the study concerning the manner in which certain occupational groups were

stereotyped and cast into the role of villains. The following section lists the recommendations, which arise from analysis and discussion of the data.

6.3: Recommendations for practice.

1. **Organisational policies should provide guidance on exact roles and responsibilities of all personnel and be made contiguous with staff educational objectives.**

2. **Hospitals may save bed days by establishing short stay medical units similar in principle to the Surgical Day Units currently established within many Trusts** (see Cooper and Connor 1999).

3. **Those persons who require complex assessment of care needs prior to discharge should be mapped through the hospital system.**

4. **Medical notes should be divided, not along lines of speciality, but along lines of important markers in hospital stay.**
   Thus notes would be divided into admission/assessment, hospitalisation and discharge making it easier to find information. At an agreed date (perhaps when medical fitness is reached) all disciplines would then proceed to write in the discharge section of the notes. In cases of worsening medical status disciplines would then revert to the relevant section of the notes.

5. **Criteria for use of discharge lounges must be more formal**.
   Ideally a medical staff member should indicate whether a patient is fit enough for the discharge lounge or not. This would mean that much of the conflict between ward staff and transport/managers would not arise.

6. **Specialist teams should devise a system of work that covers bank holidays and weekends otherwise many patients will remain in hospital unnecessarily or readmitted.**

7. **Social workers should be moved out of the hospitals and attached to specific GPs thereby providing a central point of reference for hospital nurses.**

8. **Other industries (e.g. aerospace) have instituted a system in which receipt of information is verified by both the sender and the receiver through "call-back".**

9. **It is important that the value of systems analysis is recognised and that examining instances where mistakes were made can be used to produce a safer organisation.**

10. **It is important that staff realise that ownership of a problem or information should be assumed as soon as a request is made.**

11. **All ward managers must be given the opportunity to disseminate their experience.**

12. **The ward clerks` role should be expanded to lift administrative burdens from ward staff.**

13. **Rotation is needed to overcome the deficit in knowledge of other people's roles.**

14. **Nurse handovers need to be formalised.**

15. **Multidisciplinary team meetings should be mandatory since they provide the opportunity for vital exchanges of information between all relevant parties.**

16. **It is imperative that all staff are made aware of the implications of poor discharge planning, poor documentation and poor assessment. Staff have a duty to participate fully in ensuring social preparedness as well as medical fitness.**

17. **Specialist practitioners have an obligation to pass on knowledge to more generally orientated staff and such knowledge could be used with great benefit through the use of teaching programmes in nursing homes.**

18. **An outreach team that operates from A&E (comprising all members of the multidisciplinary team) should assess patients immediately before discharge and visit them at home until community staff have enough information to provide care.**

19. **Specialist gerontologist teams should be established to provide care to those who do not fall into any other group.**

20. **Patients should be provided with information to enable them to make an informed choice about their future management in hospital.**

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APPENDICES.

Appendix: 1: Ethical clearance letters.

Our Ref: BR/MC Your Ref:

1st August, 2000

Mr B Gammon
50 Richborough Drive
Dudley
DY1 3LS

Dear Brian

Thank you for attending the Research Forum on 27th July. I am pleased to tell you that the panel has approved your research proposal and will support your research, which will take place within the Borough of Dudley.

We wish you success with the project.

Yours sincerely

Chair of the Research Forum

Nurses, Midwives and Health Visitors

Our ref: JNR/GAMM280699/jme

28th June 1999

Mr B D Gammon
50 Richborough Drive
Dudley
West Midlands
DY1 3LS

Dear Mr Gammon

Thank you for your letter (undated) which I received on 11th June.

I note that the early part of your proposed programme of research does not involve patients. There can, therefore, be no good reason for you to delay starting this until you hear formally from the LREC in

I do not wish to burden you with yet more paperwork, but my committee does rather insist that all applications to it are made on the official application form (a copy of which I enclose), both on paper as well as on disk as a Word document. I will not be able to take it to the 2nd July meeting of the LREC; there will not be time. However, if you let me have the completed application I shall take it to the September meeting. If that means too much delay for you, I should be able to give you Chairman's approval.

When filling out the application form, you do not need to repeat all the detail in your protocol; a clear summary answer to each of the questions as if you were explaining your research to a layman is what is needed.

Yours sincerely

DEPUTY DIRECTOR OF PUBLIC HEALTH

MD/JB/09.11.00 SEC 278 B Gammon.doc

9th November 2000

Mr B D Gammon
50 Richborough Drive
Dudley
DY1 3LS

Dear Mr Gammon

Re: SEC 278/031100 Getting the message across: communication and the primary/secondary health care interface

Your application to carry out the above study was considered by the Local Research Ethics Committee on 3rd November 2000.

It was noted that no questionnaire was submitted with the application. Members agreed that, subject to sight of a satisfactory questionnaire, I will be able to confirm the committees' approval for the project to proceed.

Please ensure you quote the above reference number in all future correspondence regarding this study.

Yours sincerely

CHAIR – LOCAL RESEARCH ETHICS COMMITTEE

MD/JB/05.02.01 SEC 278 B Gammon.doc

5th February 2001

Mr B D Gammon
50 Richborough Drive
Dudley
DY1 3LS

Dear Mr Gammon

Re: SEC 278/031100 Getting the message across: communication and the primary/secondary health care interface

I acknowledge receipt of your letter on 18th January 2001.

I confirm that the questionnaire received from you is satisfactory. I am therefore pleased to inform you that the committee were happy to **APPROVE** your application.

I would be grateful if you would keep the LREC informed of the progress of the study by communicating the following information to Ms Janet Bayley at the Health Authority, as soon as it is practicable:

a) any significant deviations from the protocol as submitted to the Local Research Ethics Committee and on the basis of which approval has been given;

b) any unusual and/or unexpected developments during the course of the study which raises questions about the safety of subjects;

(Cont/2.....)

Mr B D Gammon
5th February 2001

c) the outcome of the study in the form of the final report and/or any publication that results; and

d) full details if, for any reason, the study is abandoned before completion.

Please ensure you quote the above reference number in all future correspondence regarding this study.

Yours sincerely

CHAIR – LOCAL RESEARCH ETHICS COMMITTEE

Appendix:2.
Staff Interview Schedule.

Briefing: Provide participant with an overview of the interview purpose. Note the time that the interview commenced. Stress the measures taken to guard confidentiality/what will be done with the transcripts. Ask if the participant has any questions before the commencement of the interview.

Question: 1. Could you begin by defining the discharge planning process?

Question: 2. Could you define multidisciplinary teamwork?

Question: 3. What do you see as your role in the discharge planning process?

- **Consider your role in relation to doctors.**
- **Your role in relation to social workers.**
- **Your role in relation to discharge planners.**
- **Your role in relation to other specialist nurses.**

Question: 4. Has your role changed during the time you have been in the NHS?

- **Why do you think it has changed?**
- **It hasn't changed at all?**

Question: 5. Are there any aspects of your nursing role that you dislike?

- **Generally.**
- **In relation to discharge planning.**
- **Resources.**
- **Assumptions made by other health care workers or relatives/patients regarding your role.**
- **Time factors.**
- **Geography.**

Question: 6. Are there any aspects of your nursing role that you enjoy?

Question: 7. Do any elements of your nursing role confuse you?

Question: 8. Are you clear about the role of others?

Question: 9. How would you describe the relationship between nurses/doctors/ SWs and other members of the Multidisciplinary team in this department?

Question: 10. Could you describe any instances of positive communication you have been involved in?

Question: 11. How did this make you feel?

Question: 12. **Could you describe any instances of negative communication you have been involved in?**

Question: 13. **How did this make you feel?**
Question: 14. **Do you feel that you receive adequate information to be able to perform discharge planning well?**

- **In terms of general nursing education, induction days.**
- **In terms of specific hospital initiatives such as policy and other documentation.**
- **Is there a commitment to multidisciplinary teamwork?**

Question: 15. **Do you feel involved in decisions that affect you as a nurse?**

- **Trustwide.**
- **On your ward and department.**

Question: 16. **How would you describe the relationships between staff in this department/on this ward and Trust managers?**

Question: 17. **Do negative encounters with other health care professionals affect your behaviour?**

- **Practically.**
- **In terms of your feelings towards them. Are you angry, jealous, what?**

Question: 18. **If a patient is classed as a delayed discharge does that affect your relationship with that patient?**

- **In terms of nursing care.**
- **In terms of the way you feel.**
- **Examine perceptions.**
- **Use card visual analogue system at this point.**

Question: 19. **If you could make any improvement to the discharge planning process, what would it be?**

Debriefing: **Recapitulate the main points made by the participant. Give them chance to confirm or disconfirm these points. Note the time that the interview finishes, their grade and the ward. Thank the participant for their time and participation.**

Question: 20. **Do you have any questions you would like to ask?**

Appendix: 3.

The Completed Decision Trail.

The font in blue represents the final categorisation of the text from the interview reduced and analysed in appendix: 9.

- **Definitions of the discharge planning process.**

I1A (12-17, 21-23,), I3A (9-16, 260-262) I6A (15-20, 38-47), LSA(9), I2A (238-240, 245-246), I5A (6-12, 16-18) I10A (5-14, 17-21)

- **Fragmentation of service delivery.**

Across the interface: I1A (27-32, 222-225) I10A (1214-1234)

In primary care: I1A (361-366) I5A (112, 116-117)

Between A&E and the wards: I1A (427-432, 461-462) CIA (7)

Continuity: I7A (755-760) CIA (3) CIA(6), CIA(10), LSA(15) I10A (1158-1167, 583-592)

- **Communication.**

Streamlining of: I1A (255-63, 55-58) CIA(5)

Speed of process: I1A (64-66, 326, 70-74, 63-66, 260-261), I2A (263-264) I3A (718-725) I10A (901-908, 339-344, 293-299)

Accessibility/visibility improves: I1A (232-239, 247-255), I2A (261-265, 347-349, 559- 563) I5A (314-318, 326-332) I3A (667-669, 683-684, 675-679) I10A (287-291, 1277, 1283-1298)

Accessibility affects communication: I1A(260-265)

Verbal reinforcement: I1A (243) I3A (667-669, 659-662)

Fax machines: I3A (73-75)

Reliance on the telephone: I1A (248-249) I10A (1283-1298, 358-362)

Between doctors and nurses: I1A (286-289), I6A (84-99)

Between shifts of nurses (handover): I1A (289-291), I3A (75-78), I7A (743-747, 732-

739)

Between patient and relatives: I1A (349-353)

Between nurses and social workers: I1A (352-353), I3A (137-142, 148, 171-182, 155-156, 161-162, 166) LSA(9) I3A (667-669, 662-663)

Between nurses and relatives: I1A (349-353, 353-357, 376-392, 361-366)

Between nurses and patients: I7A (474-478, 482-489) I6A (437-445) I5A (76-83, 97-98, 87-93)

Between wards and pharmacy: I7A (518-525) I10A (346-356)

Between ward manager and team leaders: I7A (748-751, 732-739)

Timeliness of: I1A (353-357) LSA(4)

Confusion in: I3A (113-116, 486-491, 499-500, 509-511) LSA(10), I5A (226-235, 401-404) LSA(12) I1A (222-225, 225-238, 192-197, 201-206, 207-208, 182-188, 179-182, 286-287) I6A (344-348) I10A (967-977, 336-337)

Duplication: LSA (2) I6A (305-309, 367-382) I5A (333-339) CIA(8) I3A (539-542, 521-524, 389-393, 267-273, 315-316, 330-340)

Feedback: I2A (279-287, 295-299, 315-317), I5A (107-113) I3A (670-671, 675-679, 641-645, 649, 654) I10A (1059-1069)

Content: I2A (315-317, 306-310)

- **Problems with social work department**

Time between referral, allocation and assessment: I1A (70-74, 260-265) I3A (235-237, 242-245, 254-255, 787-788, 792-794, 798-804, 641-645, 649, 654, 539-542, 529-539) I6A (156-160) I5A (375-381, 385-389) CIA(2)

Contrasted with the discharge planners: I1A (261-263, 269-277) I3A (675-679, 609-614, 659-662)

Amount of paperwork: I1A (97-99)

Discharge date requirement: I1A (269-274, 600-603, 274-277, 281)

Perceptions amongst nurses: I3A (187, 191-195, 245-250) LSA(1) LSA(11), I6A (142-152) I5A (393-396) I3A (698-700, 662-663, 336-337, 345-347) I10A (339-344, 293-299)

- **Paperwork.**

Aftercare forms: I1A (80-106, 110), I3A (51-53, 39-40, 45-46, 83-87)
Responsibility for completion of aftercare forms: I1A (104-106)
Sharing of administrative workload: I1A (91-93, 80- 83, 90-93, 97-99) I3A (316-319)
Joint documentation and reduction in administrative workload: I1A (114-117) I3A (659-662
Nursing assessment: I1A (349-353, 362-366, 376-392) I7A (243-252,256-257,150-152) I3A (267-273) I6A (24-33, 825-838, 361-366) I10A (68-70, 390-391, 364-375, 395-413, 415-422)
Excessive amounts: I3A (59-61) I7A, I6A (386-394, 282-288, 292-301, 367-382) I7A (695-712) I10A (339-344, 364-375)
Policies: I3A (59), I6A (498-506) I10A (1300-1307)
Impreciseness: I3A (53-54, 104-107, 316-319) CIA(9) I1A (27-30) I10A (415-422)

- **Issues of responsibility.**

Access criteria as a source of conflict: I1A (122-129, 571-578,), CIA (5) I3A (100-104, 745-752) I6A (142-152), I5A (208-209, 213-218, 200-204) I10A (1131-1156)
Avoidance strategy by nurses: I1A (297-299, 308-312, 321-328, 639-643) 17A (452-455, 447-450) I2A (174-177) I10A (908-918, 1015-1026)
Nurses blame relatives/patients: I1A (343-357, 366-369, 639-643) LSA (8) I3A (756-765) I10A (1037-1049, 238-250)
Responsibility for the trolley bay: I1A (438-445)
Relatives/patients blame nurses: I7A (288-289, 290-298, 654-661) I3A (255), I6A (386-394) I10A (806-822, 445-478,
Named individuals in patient care co-ordination: I3A (38-39) I10A (37-44,
Responsibility for transfer of care: I7A (603-605, 609-612) I1A (192-197) I10A (72-78, 1214-1234)

- **Interpretation of information/language.**

Information provided by nursing staff decides who pays for care: I1A (134-140)

Dominance of medical information among nurses: I1A (291-296, 369-272, 593-603) I6A (762-768, 776-785, 717-733), I2A (108-117)

Information fade out: I1A (287-289, 291-296, 297-303)

Use of language by nurses and other staff playing the system: I5A (375-381, 385-389) I3A (756-765, 360-361, 366-368)

Censorship: I1A (470-475)

Medically fit: I1A (484-486, 487-493, 593-600, 501-505) I5A (279-281) I10A (777-786)

Cheating: I1A (612-614) CIA(9) I10A (395-413, 415-422)

Commonality: I3A (700-704, 698-700)

- **Use of resources or system.**

Bed management: I7A (243-252, 256-257) I7A (406-416, 419-431, 237-241, 664-669, 673-675, 667-678, 680-690) LSA(6) LSA(7) I2A (465-469) CIA(8) I3A (776-779, 713-714) I10A (855-858, 837-853, 806-822, 827-835, 283-284)

Budgets: I7A (87-90, 213-221) I10A (603-613)

Cancellations: I7A (300-303, 616-623, 625-627, 633-639, 644-651)

Use of system by relatives to resolve long standing social problems: I1A (148-150, 154-156, 161-164, 164-173) I10A (238-250)

Use of system by nurses and other staff to ensure desired outcome: I5A (375-381, 385-389) I10A (1131-1156)

- **Perceptions concerning speed / effectiveness of hospital over community in.**

Resolving social problems: I1A (161-173, 566)

Referrals (just in case): I1A (308-312, 216, 297-301, 316-321, 337-344) I3A (418-420, 424-428, 439-445) I10A (1309-1312)

Referrals (inappropriate) (I1A336-344) I2A (9-12) I3A (449-459, 463-469, 399-401)

Referrals (as a source of conflict): (I1A571-578), LSA (5) LSA(9)

Standards of care: I1A (355-357, 434-438, 441-450, 463-470) I7A (324-333, 598-601) LSA(7) I6A (99-104, 269-278) I5A (41-43, 47-48, 121-124, 128) I10A (777-786, 920-924, 908-918, 1015-1026, 1214-1234, 509-513, 358-362, 183-196, 415-422)

Complaints by service users, I1A (468-473) 17A (510-514) I3A (521-524, 463-469)

Lack of resources: I1A (566-571, 578-588) I6A (825-838)

Time: LSA(4) I6A (484-494) I7A (695-712) I5A (47-48, 52, 107-113) I10A (519-532, 1265-1274, 509-513, 339-344, 603-613)

Staffing: (I1A463-470) 17A (361-380, 336-403, 77-78, 58-64, 38-40, 126, 66-70) LSA(3) I6A (258-264,), I2A (117-121, 453-454, 461) I10A (346-356)

Occupational therapy: LSA (11) I6A (197-206) I3A (694-698)

Increased dependency: 17A (92-101), LSA (3) I10A (1249-1251)

Lack of planning/ disruption of plans: I7A (243-252, 256-257, 361-380) I2A (475-482) I10A (1214-1234)

Incrementalism: I7A (11-18, 6-11, 33-36, 20-21, 23, 25-27) I10A (603-613)

- **Discharge Lounge.**

Pressure from managers to move patients to: I7A (578-579, 584-595), I5A (165-173)

Information to patients regarding: I7A (474-478, 482-489, 463-470)

Advantages of using it: I7A (499-504, 508)

Conflicts with other demands: I7A (541-547, 529-530, 559-575, 559-575) I5A (165-173)

Use of by wards/continuity of care: I7A (436-437, 440, 441-445)

Safety: I7A (598-601) I10A (1214-1234)

Responsibility for patient care on transfer: I7A (603-605, 609-612)

- **Workload.**

Elective versus emergency admissions: I7A (280-287, 301-314, 266-270, 276, 313-317) I3A (729-732)

Pre-assessment Clinics: I7A (260-262, 755-760, 168-185, 233-141, 156-160, 130-131) I10A (1300-1307)

Discharges direct from wards: I7A (492-499, 755-779, 781-782, 762-768, 771) I10A (855-858, 837-853) I10A (1171-1189)

Flexibility, need for: I7A (335-338, 80-81, 83-87) I2A (29-35, 51-55, 359-376, 354-355, 417-421, 426-432, 404-405, 409) I10A (266-273)

Prioritising: I7A (541-547) I6A (386-394) I6A (568-570, 212-214) I10A (390-391)

Telephone calls: I7A (644-651, 654-661)

Other clinics: I7A (162-163, 165, 29-31)

- **Issues of role.**

Change in nursing role: I1A (36-40, 58-63, 407-409) I3A (61-62, 67-69, 28-30, 35-37, 22-24, 91, 397) LSA(7), I6A (219-250, 323-330, 314-323) I5A (31-32) I10A (979-1002, 655-659, 358-362, 85-88)

With the advent of discharge planning nurses: I1A (44-49, 36-39, 208-210, 231-235) I3A (383-385, 397-399, 373-375)

Staffing and the speed of discharge planning: I1A (63-66) LSA (5)

Perceived nursing duties/ professional rivalry: I1A (481-490, I3A (95-96, 91-95, 267-273, 273-281, 288-292) CIA(5) I6A (62-67, 99-104) I2A (128-131, 138, 157-162, 187, 192, 198-203, 208-212) I5A(349-350) I1A (508-513, 513-516) I3A (670-671, 570-592, 597-600, 604, 554-559, 563-566, 463-469, 397-399, 406-407, 411-414, 306-309, 267-273) I10A (642-653, 748-757, 620-641, 27-35, 37-44)

Idealism/ inexperience of discharge planners: I1A (494-495, 528-533, 505-508) I5A (349-357) I3A (623-626, 639-641, 360-361, 366-368)

Advocacy versus throughput: I1A (516-523, 481-490) I6A (186-193) I5A (41-43, 159-161, 200-204) I3A (837-842) I10A (791-806, 777-786, 920-924, 47-57, 1255-1260)

Pressure on nurses from other staff: I1A (134-140, 316, 480-481, 486-487, 501-516, 534, 553-557, 619-624, 639-643, 593-603, 619-625, 571-578, 528-533, 508-513) LSA(7) I10A (791-806, 777-786, 695-703, 266-273, 277-282)

Perceived usefulness of nurses` role by nurses: I1A (144-147) I6A (67-77) LSB (16) I10A (979-1002, 655-659)

Misconceptions of nurses role by nurses: I7A (203-207, 122-124) I3A 519-521)

Favouritism: I3A (126-128, 128-131, 211-213, 223-224, 195-196, 202-203, 267-273) I1A (630-634, 625-626) I10A (1201-1212, 1013-1015)

Specialisation: I6A (657-664) I2A (108-117, 40-44, 121-123, 444-447) I3A (486-491, 499-500, 509-511, 449-459, 469-470, 477-479, 352-356, 297-298, 304-306) I10A (979-1002, 926-929, 908-918, 901-908, 939, 941-951, 27-35, 293-299, 85-88)

Misconceptions regarding social worker's role among nurses: I1A (186-188)

I1A(192-207), I3A (228-230)

Direct contact/experience as an aid to understanding: I1A (207-210, 214-217, 185-188) I2A (386-394) I10A (666-672, 205-216, 183-196)

- **Doctors.**

Refusal to become involved in disputes: I1A (136-137, 607) I3A (776-779, 770-771, 775-776, 736-740)

Power of medical staff: I1A (492-494, 558-560) I3A (729-732) I10A (791-806)

Consultant idiosyncrasies: I1A (578-588)

- **Understanding the system, mystery and fatalism.**

Confusion concerning system: 179-182, 222-225) I10A (1300-1307, 109-112, 114-118, 120, 122-128, 130-134)

Change as a cause of confusion: I1A (182-184) I10A (68-70)

Stasis within the system and type of patient: I1A (201-207) I3A (818-819)

- **Organisational influences upon understanding.**

Geography: I1A (216-217) I3A (785) I2A (253-257)

Status: I1A (216-217) I10A (953-965)

Nursing culture: I2A (517-530) I1A (297, 634-639, 630-634) I10A (666-672, 597-601, 1026-1035, 565-573, 534-551, 494-501, 434-442, 673-692, 660-666, 503-506, 642-653, 620-641)

Relatives` understanding: I1A (366-369, 376-392)

Perceived inequalities within organisation: I1A (459-462, 463-470, 553-558) I7A (92-101) I2A (490, 495-509) I3A (519-521) I10A (837-853) I10A (252-264, 302-306, 1131-1156)

- **Lack of knowledge.**

Between disciplines: I2A (108-117, 142-147) I10A (967-977, 1265-1274, 205-216,

705-714, 723-729, 37-44)

Of nursing by managers: I7A (229-235, 197-200, 532-534, 536-539, 42-43, 55-58, 115-122, 104-113)

Attempts to redress knowledge deficit of managers by nurse: I7A (185-187, 191-195, 225-229)

- **Relationships.**

Distance of managers from front line: I7A (641-644)

Stability of teams: 232-233, I6A (404-412)

Relationship between nursing grades: I3A (325-328) I6A (643-648) I3A (700-704, 659-662) I10A (920-924, 864-890)

Nurses and managers: I1A (407-409, 445-459,421-423, 427-434) I7A (341-345, 347-360) I6A (562-564, 553-558, 532-543, 588-593, 574-578, 598-610) I5A (187-189, 179-183, 194-196) LSA (14) I10A (777-786, 415-422)

Differing priorities: I1A (421-423, 450-457, 474-475)

Personal versus professional: I1A(549-553) I6A (619-634), I2A (90-97, 77-85) I10A (766-770) I10A (1078-1112)

Between nurse and patient: I1A (630-643, 619-626, 549-553) I6A (115-121, 269-278) I5A (244, 248-252, 254, 256-261) I3A (837-842) I10A (766-770, 894-898, 156-165, 167-172, 431-432, 479-487, 739-747, 390-391, 1158-1167, 642-653, 748-757, 445-478)

Between doctor and nurse: I6A (417-427, 404-412, 460-470, 54-58) I2A (322-328, 337-341) LSA(14) I10A (174-179, 322-324, 167-172, 1059-1069, 27-35, 109-112, 114-118, 120, 122-128, 130-134)

Appendix: 4.

Observations from The Royal Wolverhampton Hospitals NHS Trust.

This appendix contains observations and comments on the discharge planning process as seen at The Royal Wolverhampton Hospitals NHS Trust. Although it was not originally intended to collect data from this facility, the opportunity did arise and for the sake of completeness this data has been included. Although ethical approval was not sought, any documentary evidence used here is of a non-confidential nature and is easily accessible, enjoying Trust-wide circulation. These are the observations of an employee and although all steps have been taken to present a balanced view, the author recognises that the picture may be incomplete and that distortion may occur. The author recognises, furthermore, that all staff work with commitment and dedication in the most trying of circumstances. The unique insider view of the bed management and discharge planning processes afforded to the post holder forced the inclusion of this information in the thesis.

During the period August 2002 to October 2003 the candidate was employed by Royal Wolverhampton Hospitals NHS Trust as an Admissions and Discharge Co-ordinator/ Bed Manager. The team consisted of three people for the medical, surgical, critical care and rehabilitation wards at the New Cross site. The rationale of the post was to ensure the smooth and timely discharge of individuals from secondary to primary care, thereby ensuring the effective utilisation of beds within the Trust. The role was carried out within the context of increasing weekly numbers of emergency medical admissions year-on-year (see figure 12.1 below).

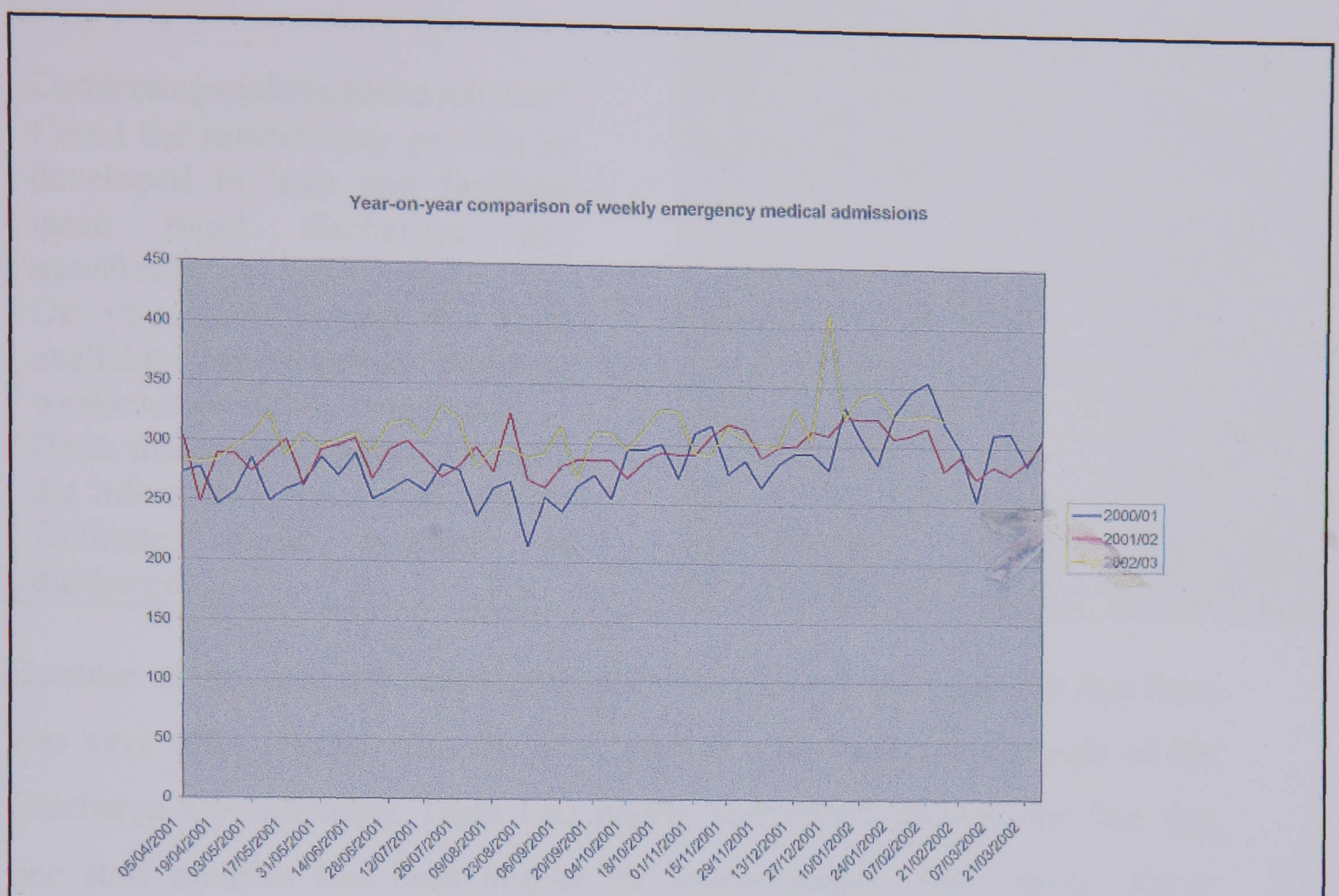

Figure: 12.1. Year On Year Comparison of Weekly Emergency Medical Admissions.

The picture of service provision by the Discharge Co-ordinating Team revealed from a small group of questionnaire respondents (Dodds, personal correspondence) was varied and inconsistent. Of thirty questionnaires, twelve were returned giving a response rate of forty percent. The results are tabulated and discussed below (Table: 12.1).

Table: 12.1 Responses to Ward Managers` Questionnaire.

Question.	Yes (%)	No (%)	Don't know (%)
Do the team provide the service you want?	5 (42)	4 (33)	5 (42)
Could the service they provide be developed to help you facilitate more rapid discharges and transfers?	5 (42)	1 (8)	6 (50)
Do you think having the team available for extended hours at weekends would be beneficial?	6 (50)	4 (33)	2 (17)
Does the team provide you with the information your staff need to facilitate rapid transfer or discharge?	6 (50)	2 (17)	4 (33)

Because of the large catchment area of the team, ward managers felt that there was very little contact with the team and as a consequence the role of the Discharge Co-ordinating Team was poorly understood (despite the fact that one staff member had been in-post for approximately three years). Other comments included the fact that pressure is perceived to be put on ward staff to move patients quickly or inappropriately without appreciating "the bigger picture". Inappropriateness was defined as discharge or transfer before all agencies were in place or discharge or transfer which was perceived to conflict against clinical need.

Sometimes, however, the Discharge Co-ordinating Team were not perceived to act quickly enough. This may parallel findings in other Trusts concerning role perception and the way professional domains and boundaries are guarded through the aggregation of tasks which are seen as belonging uniquely to one or other occupational group. If a patient is unpopular initially because he or she is seen as undeserving of admission either to hospital or to a particular speciality (e.g. outliers) then nursing staff will generally attempt to have the patient discharged or transferred at the earliest opportunity. Failure to achieve this desired end is likely to result in blame upon agencies who are perceived to have the most influence in the area of discharge. Hence discharge co-ordinators are perceived to be acting too slowly. If, however, the need to discharge a patient who is not unpopular overrides the nurses` clinical

judgement then this becomes an issue of professional integrity and attempts will be made by nurses to assert that the clinical situation demands that a patient remains in hospital. This is difficult to substantiate, however, since there were times during the data collection phase at other Trusts where patients were discharged too soon (as evidenced by readmission rates given on the Department of Health website. Equally, however, it is not unfair to comment that during time spent in the field there were instances of nurses and other staff articulating professional jealousies through the medium of patient centred, altruistic language.

The majority of those (83%) who responded to question two felt that the Discharge Co-ordinators could develop their service to facilitate more rapid discharge and transfers. Ward managers felt that this could be achieved through better education of staff and raising the profile of the service. Ward managers also felt that there was some duplication in the service as indeed there was. It was commented upon that often two discharge co-ordinators would attend wards at different times to request the same information and that sometimes duplication or non-performance occurs because too many people are involved. This was a charge levelled at bed managers and discharge planners at other Trusts. The fact that ward managers saw the need for a "bed management/discharge team to ensure patients are in the appropriate bed" highlights the fact that ward managers do not seem to distinguish between the two and furthermore that it is a widely held perception that there are a significant number of patients who are placed into inappropriate beds. Communication quality was perceived to be poor. Clla for better liaison between the Discharge Co-ordinators and the ward staff were noted. Specific mention was made of the need to assist in finding facilities for head injured patients. This reflects a strategic issue concerning lack of service provision and although this charge can hardly be laid at the feet of the Discharge Co-ordinators it suggests that more needs to be done to target specific groups. Homeless people for example form a small but significant cause of delayed discharge in the Wolverhampton area and these individuals remain in hospital because there is nowhere else that they can be accommodated. Drug rehabilitation services are also at a premium.

Ward managers saw the role of the Discharge Co-ordinators as being particularly important in the following areas:

- Facilitating referrals (n=6).
- Checking appropriate referrals have been completed (n=5).
- Liaising with external agencies on behalf of ward staff (n=8).
- Arranging transport for patients (n=4).
- Ensuring all requirements [sic] are in place prior to discharge (n=6).

Other suggestions included action to speed up other agencies, provide alternative suggestions in an attempt to resolve complex problems, provide access to temporary community support and "chasing up" social workers who claim a referral has been lost. Having a service provided by the Discharge Co-ordinators at weekends was seen as potentially beneficial (especially in winter) because discharge planning is seen to end on a Friday afternoon. Expansion of the service to cover weekends would lead to the prevention of crisis bed management and would enable greater fluidity of admissions and discharges to ward areas.

The most telling criticism of the Discharge Co-ordinators was the fact that earlier involvement was needed with "problem discharges". There was a perception that the role of the Discharge Co-ordinator was more of a day-to-day emergency bed management rather than, one assumes, an evolving process. Discharge planning was felt to be rushed which led to breakdowns in communication or omissions in care delivery. There was a recognition of the fact that the Discharge Co-ordinators were busy and the demands made by management for continuous and up to date bed states meant that the discharge planning element was neglected. This incrementalism meant that the Discharge Co-ordinating Service was also expected to manage step-down beds in local nursing homes and become Nursing Care Assessors. The Discharge Co-ordinators felt that the breadth and scope of their role was increasing and they could not, therefore, fulfil all demands satisfactorily. This was especially the case because continuous high occupancy meant demand was high and

constant. Bed crises were an almost daily occurrence and because of this the bed management function predominated. This meant that it was physically impossible to institute a system along the lines of the Discharge Planner where one person is allocated the case from beginning to end.

The hurried nature of the discharge planning process in the light of increased pressure to accommodate emergency admissions is highlighted in Discharge/Transfer Cause for Concern meetings which are held monthly in Wolverhampton. As of February 2003 there were 48 items on database and these were then classified as follows (Table: 21.2 below).

Table: 12.2. Discharge Causes for Concern at Royal Wolverhampton NHS Trust.

Cause for concern (%)	**Comments**
Receiving unit/team not informed of transfer/discharge (35%).	This ranges from teams who are expected to give planned input on discharge not being informed of discharge home, to nursing homes or resource centres having patient arrive without notice being given.
Inappropriate discharge or transfer (23%).	Staff generally felt that patients were too ill to be moved to a unit of less dependency.
Discharges without community nursing/social care arrangements in place (12%).	Where professionals have become involved with patients who have had no care package in place on discharge.
Discharge/transfer before assessed (9%).	This involves patient notes or drug treatment sheets not being sent with patients as they move between units or when important information regarding patient management has not been passed on.

"The above incidents", the authors note, "are reported on a frequent basis and are mainly based around poor discharge planning or lack of communication". Other incidents which are reported (though less frequently) are referrals for assessment being made too late in the discharge planning process, patients being transferred late in the day, or patients being discharged from step-down beds without planned follow up intervention.

Experience, therefore, leads one to suggest that the discharge planning and bed management elements of capacity management should be kept separate. Combining the two appears to lead to a situation in which the process of capacity management is skewed in favour of admissions since attention is invariably focused on A&E and Medical Admissions Units. Combining the two roles provides the temptation to discharge people too early in order that waiting times and elective targets may be met. This is short-sighted, however, since significant numbers of those who are discharged will be readmitted within twenty-eight days thus compounding the problem. Two separate functions will restore some of the checks and balances necessary to ensure that people are both medically fit and socially prepared to resume life outside the hospital. Separate functions will restore some degree of patient advocacy which is lacking in the discharge planning process.

Many of the problems encountered by patients and staff in the implementation of the discharge planning process arise because of the vast complexity of the system. In the case of health care in Wolverhampton, an examination of the many different information pathways was carried out. The chief bodies involved where:

- Social Services (non-emergency).
- Social Services (emergency).
- Community Mental Health.
- ICES (Integrated Community Equipment Services).
- Community Intermediate Care Team.
- West Park Wards (non-acute rehabilitation).
- T Block (acute rehabilitation).
- New Cross Acute Wards.
- Home visits and Out-Patients.
- Initial contacts.
- Compton Hospice.

The results are given below (Figure: 12.2).

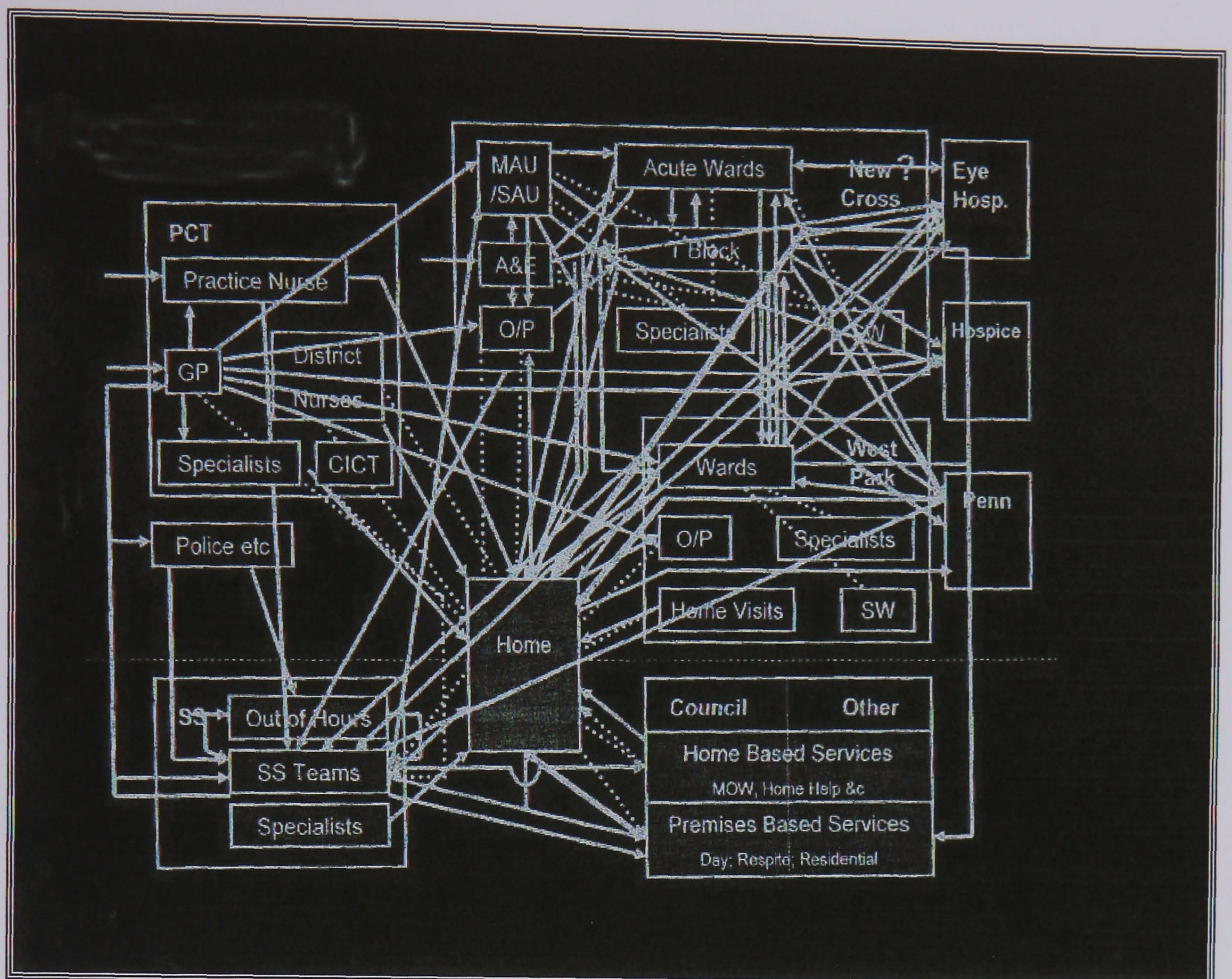

Figure: 12.2. Social Care and Health Care Referral Pathways in Wolverhampton.

Coupled with the complex communication and referral mechanisms which currently exist within Wolverhampton (indeed within all hospitals studied) there is the question of appropriate placement. A patient census was carried out within Wolverhampton HA to assess the needs and current placement trends of patients in order to inform the capacity planning process. The results of this census revealed that, in common with all other hospitals studies, there was a shortfall in capacity in certain areas and that a significant number of patients were occupying acute beds when their need might be better served in a non-acute environment. The results are woth discussing at length since they provide succinct information on problems which beset almost all hospitals within the acute and rehabilitative sectors of the NHS. Those people determined as requiring ongoing care are particularly liable to find themselves in hospital for longer than is necessary. "Ongoing care" is defined as "people

who have no significant potential for change with rehabilitation input". In other words they fail to meet any criteria for resource centres or West Park Hospital. This sizeable population will await nursing homes, step-down beds or may become delayed discharges on T-Block when pressure on beds necessitates their removal from the acute wards.

If one examines the type of patient served by the New Cross main site the following emerges.

Service	Percent	Number
Acute	79	408
Palliative	1.5	8
Ongoing	9	47
Rehab	10	53
HAH	0.5	2

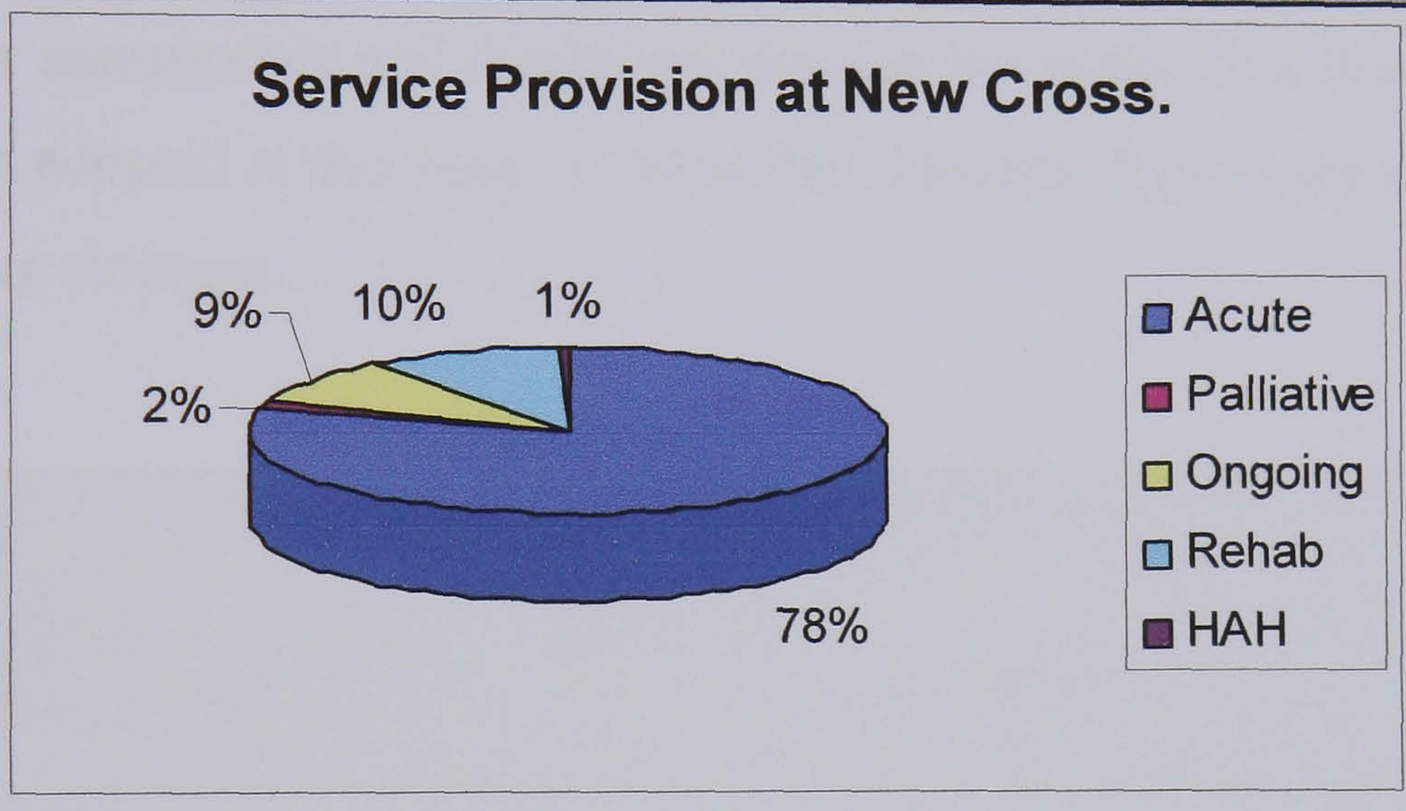

Figure: 12.4. Service Provision by type at New Cross Main Site.

It is immediately apparent that a significant percentage of persons within New Cross Hospital are inappropriately placed. Certainly, by definition, those persons requiring the services of Hospital at Home programmes (HAH) should be managed at home. Regarding rehabilitation services, the picture is more complex since it is unclear whether these persons require acute rehabilitation (in which case they require lodgement in T Block and would, therefore, be appropriately placed within New Cross. Non-acute rehabilitation is provided at West Park Hospital and a number of resource centres managed by social services. Although the exact numbers of rehabilitation patients cannot, therefore, be calculated exactly, staff on T Block routinely bemoaned the fact that there were a number of delayed discharges who were suitable for step-down whilst awaiting social services input or while awaiting agreement

among family members. It was noticeable that, in times of acute pressure on beds, every effort was made to fill vacant West Park and T Block beds with the result that patients were inappropriately placed on a number of occasions.

The number of palliative patients in the acute care setting reflects the small number of community providers in this area. Reliance was predominantly upon Compton Hospice providing beds and services and there was a significant waiting list. It should also not be forgotten that the sudden changes in condition that palliative patients may undergo may necessitate their remaining in hospital. The fact remains, however, that (based on the above figures) between three and twenty three percent of patients are inappropriately placed. The impreciseness of the figures is revealing. It was planned to map complex assessments and discharges through the system but this strategy has not been adopted at this time. If West Park Hospital figures are examined, the following emerges.

Service	Percent	Number
Acute	2	2
Palliative	2	2
On-going	23	24
Rehab	69	67
HAH	6	6

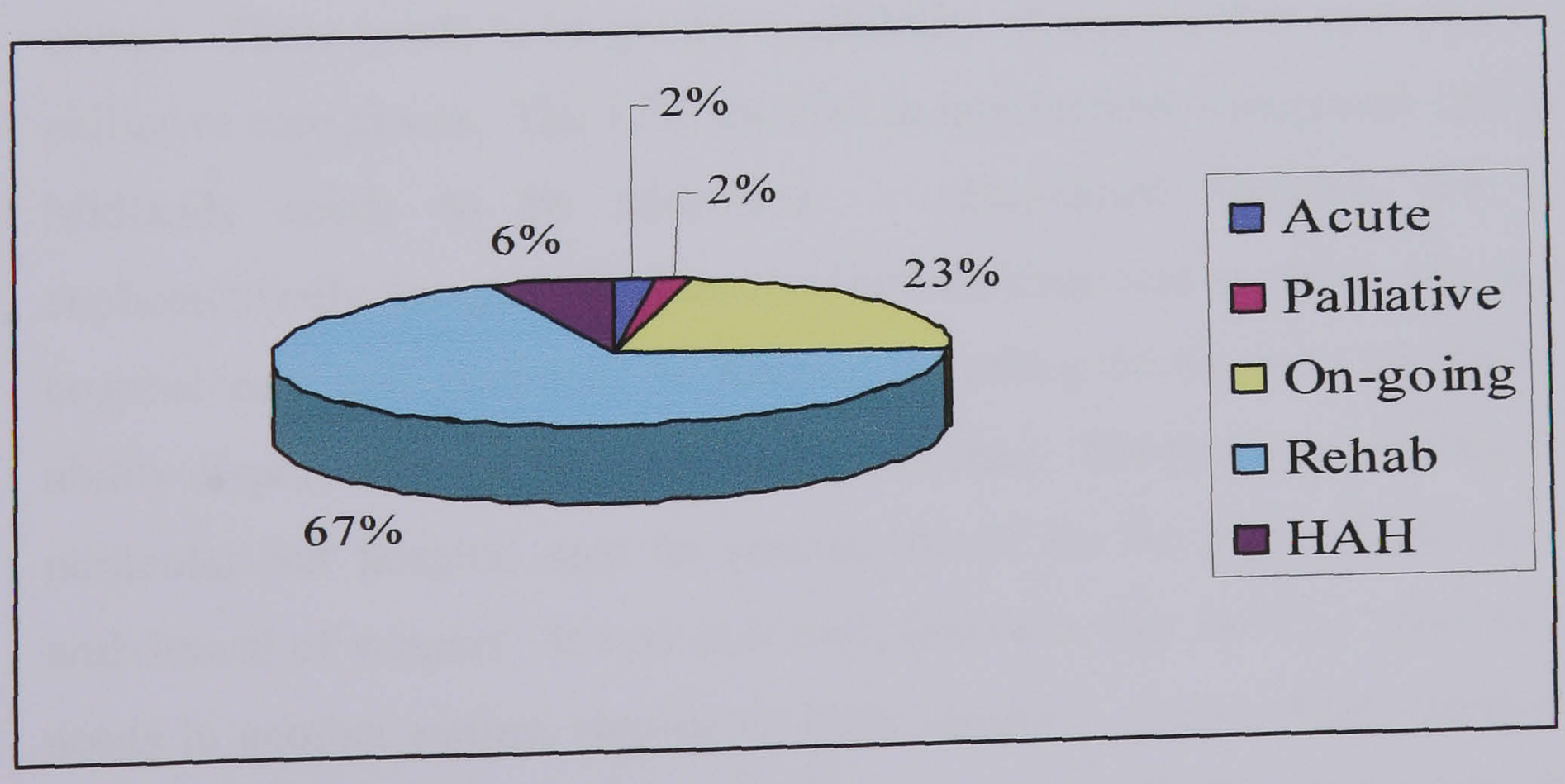

Figure: 12.5. Occupancy at West Park Hospital by Category.

From the above it is obvious that by far the biggest barrier to appropriate bed use at West Park is the number of patients in the ongoing category. If they

cannot benefit from rehabilitation they have been placed in a rehabilitation hospital solely due to bed pressures at the acute facility. Twenty four patients assigned this category were at West Park Hospital during the census (New Cross housed 47). The conclusions and recommendations of the report were that:

- "The system appears to have a significant lack of provision for people with ongoing care needs and a lack of an effective process for identifying such patients and placing them in appropriate provision efficiently".
- "The system has approximately the necessary total quantity of rehabilitation provision when assessed against need. However, the current quantity of particular rehabilitation services is not necessarily the right mix".
- "There is a failure to match patient rehabilitation needs with service allocation".
- "There is a failure to provide effective non-hospital based options for a significant number of patients needing palliative care, particularly non-cancer [patients]".

The proposed recommendations are saturated with the language of cost-effectiveness and efficiency. Certain conclusions are, however, difficult to escape. There needs to be greater availability of intermediate care places and palliative care places. The 17% shortfall in intermediate care places within the Midlands needs to be addressed. Step-down facilities are often euphemistically thought of as places of intermediate care in which the required hospital care will gradually be reduced according to the level of functional ability displayed by an individual at a given time. The goal of rehabilitation in particular but hospital care in general should be the planned and gradual withdrawal of support. It was observed, however, that far from meeting care needs in another setting, step-down beds became a means of providing more acute capacity and a number of patients were readmitted from step-down facilities as emergencies. Furthermore, boundary disputes were most obvious in trying to provide services to patients within step-down facilities. Although

agreements by GPs to provide services are formalised, community physiotherapists declined to provide services because the step-down facility is the responsibility of the hospital management. Hospital physiotherapists also declined to provide services. The whole step-down system also proved prohibitively expensive and did not have the effect on acute capacity that a longer term planned reappraisal of services would have. The problem of delayed discharges was simply passed on to the step-down home. The period of step-down was two weeks (three in certain circumstances) but this was routinely exceeded principally due to problems in arranging care packages or alternative accommodation (that is problems of a social nature).

Attendance at "SITREP" meetings also revealed that the reasons for delays are diverse but (like Kibbler`s findings and the findings from Trust A and Trust B) the majority were caused by delay in assessment and a delay in placement due to lack of capacity. One group who consistently fail to benefit from current service provision is the elderly mentally ill. They are likely to be therapeutically and emotionally demanding and to have multiple health needs. Many homes (even those registered to care for such a client group) refuse to take this type of person and it is not uncommon to have to find another placement at short notice to prevent readmission to hospital. Plainly greater attention needs to be paid to an individualised assessment process in these instances and tailored capacity needs to be made available.

The current need to meet targets also has a deleterious effect on the ability to provide a discharge planning service centred upon the patient and continuous in its duration. During the time of employment the researcher was involved in the A&E audit week in which at least 90% of attendees in A&E had to be discharged or admitted to a ward within four hours. This placed tremendous pressure on ward staff and led to inappropriate discharges. The reasons for this included the fact that consultants were not always based in the Medical Assessment Unit and yet when they were, there was a noticeable drop in the number of admissions. Furthermore, there were a number of inappropriate admissions or attempts at admission by GPs. One person was sent to MAU because they had lost their house keys, homeless people are routinely brought

in. One doctor commented that successive governments had reduced bed numbers and until this deficiency is addressed either by curtailing admissions or allowing the number of beds to rise and occupancy rates to fall, the present system will continue and will not to beneficially influenced by the imposition of targets. As a measure of the effectiveness of targets, figure: 12.6 (below) gives ambulance waiting times as recorded by ambulance control and the staff at New Cross. There is significant difference in measurement between the two parties. Whilst it is impossible to account for the underestimation by ambulance control, a sister informed me that the reson many ambulance crews appeared to be waiting longer than the nurses recorded was because ambulance crews left the department having had a drink but that unofficial break was recorded as waiting time by ambulance control as the crews would radio that they were available after they had had their drink. For targets to give some indication of resource disposition and progress they must surely be used in the same manner.

Despite this, the problem of ambulance waits remains serious in many portals of admission. Data from New Cross Hospital indicates that the highest number of referrals to the Supportive Discharge Service emanated from those areas from which patients would exit the system in particular rehabilitation wards, and cardiology with most emanating from the Medical Assessment Unit and its satellite ward. This would be expected to occur because of the fact that these patients were nearing their discharge date, but the huge difference between MAU suggests that staff are attempting to free up capacity by discharging patients when ward beds are at a premium. It may also suggest that the general wards do not use this service as much as they are able too and finally that discharges are not planned in advance. Generally, the SDS was contacted at most two days before discharge and more commonly on the day of discharge.

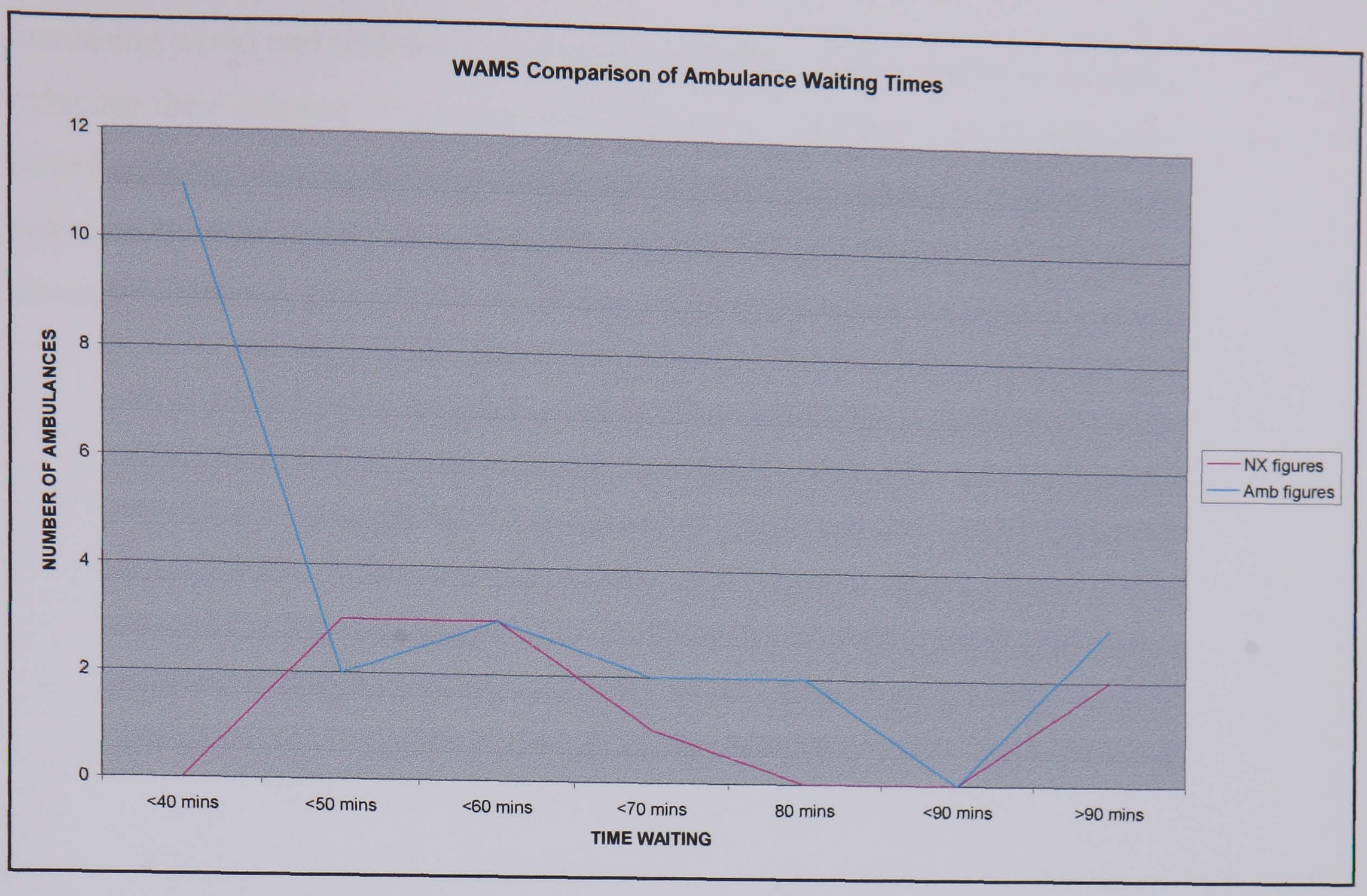

Figure: 12.6. West Midlands Ambulance Service versus New Cross Hospital: comparative waiting times.

To conclude, New Cross Hospital suffers from exactly the same kind of problems as Trust A and Trust B. Lack of exit strategy, tremendous pressure on resources and inadequate funding all play a part in fragmenting longer term planning. In fact, New Cross may have significantly worse problems with bed management because of the system put in place across the Midlands. The Capacity Management System (CMS) was designed to both flag up empty beds and to ensure that admissions were evenly distributed throughout the region thereby reducing workload. A reallocation quota is given to each hospital on a morning. Once this quota has been reached the hospital can only accept patients from its own catchment area until other hospitals have reached their reallocation point. All other patients must be sent to other hospitals. Although the reallocation point is calculated on the number of beds available set against the previous days admission numbers, it always appeared that other hospitals reached their reallocation point first (as New Cross has more beds). This resulted in New Cross being regularly inundated with patients from other hospitals as well as those who consultants based at New Cross wished to admit. Hospitals throughout the region find themselves asked to manager an

increasing workl oad with fewer and fewer resources. If they are successful in reducing their delayed discharges then the funding available will be reduced from levels which are already insufficient. This cannot carry on indefinitely, both levels of experienced staff and the patient experience is already being adversely affected...